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REPORT ON MONITORING OF POPULATION POLICIES

SUMMARY */

This report is the third in a series prepared pursuant to a recommendation of the World Population Plan of Action that monitoring of population trends and policies should be undertaken continuously as a specialized activity of the United Nations and reviewed biennially by the appropriate bodies of the United Nations system, beginning in 1977.

The part on monitoring of population policies, which is presented in this document, covers various aspects of governmental perceptions and policies in relation to population growth, mortality, fertility, and international migration.

The first part, dealing with population trends, is presented in document ESA/P/WP.68.

*/ Preliminary version to be finalized after review by the Population Commission at its twenty-first session held in New York from 26 January to 4 February 1981.

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INTRODUCTION

The third report on monitoring of population policies was prepared in accordance with a recommendation of the World Population Plan of Action adopted by the World Population Conference, Bucharest, 1974, that monitoring of population trends and policies "should be undertaken continuously as a specialized activity of the United Nations and revised biennially by the appropriate bodies of the United Nations system, beginning in 1977." 1/

The present report on population policies is divided into four chapters, dealing with population growth, mortality, fertility, and international migration. 2/ The four chapters consist of an introduction, a discussion of major issues and changes by level of development and area of responsibility of each regional commission, and some general concluding remarks. The chapter on international migration policies has been organized differently from the others, in that it examines major migratory flows and related policies within and between regions and not by levels of development.

This third round of monitoring of population policies focuses more, as had already been the case for the second round, on measures rather than perceptions, examining in the selected areas of the report the emphasis of governments. 3/ To ensure continuity between the second and third round of monitoring of population policies, the same basic tables have been retained and have been updated to reflect changes in perceptions and policies between 1978 and 1980. 4/

Particular attention has been given to measures related to fertility and international migration both in developed and developing countries. The material from the Fourth Inquiry was heavily supplemented and updated with material from the Population Policy Data Bank. Although the experience of all Governments have not been examined in the text, the annex tables list the perceptions and policies of all Governments in 1980 (the tables are organized by region and by level of development). The text of the present monitoring report includes a number of summary tables by 24 subregions.

This text is not as yet in its final form. It will be revised in 1981 taking into account any comments from the Population Commission, as well as comments from Governments, the specialized agencies, and the regional commissions.

1/ Report of the United Nations World Population Conference, 1974 United Nations Publication, Sales No.: E.75.XIII.3), part one, chap.I, para 10.

2/ The policies relative to the spatial distribution of the population will be the subject of an extensive review in the fourth round of population policies.

3/ World Population Trends and Policies: 1979 Monitoring Report, Vol. II (United Nations publication, Sales No. E.79.XIII.5).

4/ See the annex tables to the present report.

Chapitre 17
ACCROISSEMENT NATUREL DE LA POPULATION

Introduction

L'évolution des taux d'accroissement naturel de la population constitue une des préoccupations fondamentales de la plupart des gouvernements aussi bien dans les pays développés que dans les pays en développement 1/. C'est aussi un des lieux privilégiés de leur action dans le domaine démographique. De moins en moins nombreux sont les gouvernements qui ne considèrent aujourd'hui que la maîtrise des différents paramètres de l'évolution de leur population se soit de leur responsabilité et ne présente un enjeu d'une importance vitale pour le succès des plans de développement de leur pays. L'appréciation que portent les gouvernements sur les répercussions éventuelles de la situation démographique sur la réalisation des objectifs de développement est le résultat d'un processus complexe qu'on peut cependant schématiser de la façon suivante : les gouvernements procèdent à une analyse des avantages et des inconvénients à court, moyen et long terme du taux d'accroissement naturel de la population pour la réalisation des différents objectifs économiques et sociaux, globaux et individuels, régionaux et sectoriels qu'ils se sont fixé.

C'est au terme de cette analyse qui les conduit à une évaluation du solde net des avantages par rapport aux inconvénients, et donc à une perception d'ensemble sur le caractère acceptable ou non des taux d'accroissement naturel, que les gouvernements décident ou non d'intervenir. Dans cette optique, une attitude de non intervention représente aussi une option politique dans la mesure où les gouvernements n'intervenant pas adoptent cette attitude après avoir procédé à une analyse de la situation. Les gouvernements font confiance aux mécanismes d'évolution spontanée, ou bien estiment inopportun, dans le contexte politique et social du pays, d'agir directement ou indirectement dans le domaine démographique.

Une fois prise la décision d'intervenir, les gouvernements sont confrontés au problème du choix des moyens d'action à mettre en oeuvre et de l'intensité de leur intervention. Les interventions gouvernementales peuvent se regrouper en deux grandes catégories : d'une part les interventions directes ou indirectes sur les processus démographiques comme la fécondité, la mortalité, les migrations internes et les migrations internationales et, d'autre part, les interventions sur les facteurs socio-économiques permettant de créer ou de recréer un équilibre entre évolution économique et démographique. En fait, on constate que rares sont les interventions unidimensionnelles : ce sont des combinaisons d'interventions à caractère multidimensionnel qui sont le plus souvent retenues par les gouvernements. Lorsque la décision d'intervention est prise, et lorsque le choix des moyens d'action est déterminé, il reste encore aux gouvernements à décider de

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1/ L'accent est mis sur l'accroissement naturel de la population plutôt que sur la croissance de la population, car la plupart des pays ne considèrent pas les migrations internationales comme démographiquement importantes. Pour les autres, le recours aux migrations internationales constitue une réponse à un taux d'accroissement naturel perçu comme non satisfaisant. Dans le présent chapitre, afin d'alléger le style, nous utiliserons le terme "accroissement" pour accroissement naturel de la population.

l'intensité avec laquelle ils mettront en oeuvre leur politique et des moyens qu'ils seront prêts à engager suivant la gravité perçue de la situation. Le soutien peut être global ou partiel.

Dans le cas d'intervention globale, la volonté gouvernementale se manifeste par une prise de position officielle indiquant le sens de l'action, par le choix d'un ensemble d'interventions variées sur les processus démographiques et non démographiques, par une indication sans ambiguité des objectifs poursuivis, par l'attribution de ressources importantes pour mettre en oeuvre la politique choisie, etc.

Dans le cas d'un soutien partiel, les objectifs poursuivis sont en général multiples et l'objectif démographique n'est plus prépondérant. On observe rarement de prise de position officielle, souvent d'ailleurs pour des raisons d'opportunité politique. L'éventail des mesures adoptées et les moyens financiers mis en oeuvre est plus limité.

Dans la suite de cet exposé, nous ferons le point de la situation au ler juillet 1980, des perceptions et des politiques gouvernementales relatives à l'accroissement. Une attention particulière sera donnée aux changements survenus durant la période 1978-1980. 2/

Cet examen des perceptions et des politiques gouvernementales concernant le taux d'accroissement s'inscrit toujours dans ce mouvement de décélération de la croissance démographique amorcée dans le début des années 1960 dans les pays développés, un peu plus tardivement dans les pays en développement.

Ce mouvement a pris une telle ampleur dans certains pays développés que le taux d'accroissement naturel est maintenant négatif et que la population par conséquent décroît.

Le taux d'accroissement de la population mondiale pour l'année 1980 3/ est estimé à 1,8 p. 100; en 1960 le taux atteignait 2,0 p. 100. Dans les pays développés le taux est tombé de 1,1 p. 100 en 1960 à 0,6 p. 100 en 1980; durant le même période le taux passait de 2,4 p. 100 à 2,2 p. 100 dans les pays en développement. Comme nous l'avons déjà mentionné précédemment, le taux est en baisse partout, à l'exception notable de l'Afrique où il est en hausse : de

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2/ Il faut indiquer ici que les changements de perceptions et de politiques dont il est question dans ce rapport correspondent à des changements de catégories déterminées de façon conventionnelle. Une analyse fine, menée au niveau national, montrerait que, dans la majorité des cas, les changements se manifestent de façon continue et non pas discontinue comme une analyse schématique peut le suggérer. On pourra cependant remarquer que la conception même des tableaux à partir desquels ces changements sont repérés dans ce chapitre, représente un effort de représentation du caractère progressif de ces changements.

3/ United Nations, Department of Economic and Social Affairs. Selected World Demographic Indicators by Countries, 1950-2000 unpublished document. (As assessed 1978)

2,5 p. 100 en 1960 à 3,0 p. 100 en 1980; mais le rythme du déclin varie d'une région à l'autre, plus prononcé en Asie orientale par exemple, mais très lent en Amérique latine.

C'est donc dans cette perspective que nous devons examiner les perceptions et politiques gouvernementales concernant l'accroissement. A l'échelle mondiale, 75 pays sur 165 (soit 46 p. 100) considèrent leur taux d'accroissement comme satisfaisant. En 1978 ils étaient 76 sur un total de 158 pays. 35 autres (soit 21 p. 100 des pays) estiment qu'un taux plus élevé est désirable; ils étaient 36 en 1978. Finalement 55 pays (soit 33 p. 100 des pays) souhaitent un taux plus bas. En 1978, ils étaient 46 pays dans cette catégorie de perception. Cette augmentation importante est principalement due au fait que les 7 pays, devenus indépendants depuis 1978, souhaitent tous un taux d'accroissement plus bas (Zimbabwe en Afrique; Dominique, Sainte-Lucie et Saint-Vincent-et-Grenadines en Amérique Latine; les Iles Salomon, Kiribati et Tuvalu dans la région économique de l'Asie).

Dans les pays développés la situation est la suivante : 11 pays sur 39 (28 p. 100 des pays développés) souhaitent un taux plus élevé, 28 (soit 72 p. 100) se déclarent satisfaits et aucun ne souhaite un taux plus bas. Dans les pays en développement, la situation est pratiquement inverse : 24 pays sur 126 (soit 19 p. 100 des pays en développement) souhaitent un taux plus élevé, 47 (37 p. 100) se déclarent satisfaits et 55 (44 p. 100) souhaitent un taux plus bas. Dans les pays en développement, c'est donc 63 p. 100 des pays qui ne sont pas satisfaits de leur taux contre 28 p. 100 seulement dans les pays développés (cf. tableau 1 et 2). L'écart entre la distribution des perceptions par rapport au niveau de développement s'accentue encore plus nettement dans une statistique par population : 29 p. 100 de la population mondiale réside dans des pays satisfaits de leur taux d'accroissement naturel, ce qui représente 64 p. 100 de la population des pays développés et seulement 17 p. 100 de la population des pays en développement. Le reste, soit 71 p. 100 de la population, réside dans des pays non satisfaits du taux (12 p. 100 parce que le taux est trop bas, 59 p. 100 parce qu'il est trop élevé). Par niveau de développement ces pourcentages deviennent respectivement : 36 p. 100 de la population des pays développés résident dans des pays non satisfaits de leur taux, mais tous parce que ce taux est trop bas; 83 p. 100 de la population des pays en développement réside dans des pays non satisfaits du taux, mais 4 p. 100 parce que le taux est trop bas et 79 p. 100 parce qu'il est trop élevé (cf. tableau 3). Cette accentuation de l'écart entre la distribution des perceptions par nombre de pays et suivant la population est causée par le poids démographique considérable des grands pays d'Asie qui tous souhaitent un taux d'accroissement plus bas.

Nous avons examiné la distribution des perceptions gouvernementales concernant l'accroissement de la population dans la perspective du déclin généralisé de ce taux. On peut aussi considérer cette répartition des perceptions en relation avec le niveau du taux et le volume de la population. Dans le tableau 4, A et B, les pays sont classés selon leur perception du taux d'accroissement de la population et le niveau de ce taux.

On constate que parmi les pays développés où le taux est pratiquement partout inférieur à 1,5 p. 100, un tiers environ considère ce taux trop bas, mais deux tiers s'en montrent satisfaits, notamment ceux où le taux est précisément le plus bas (12 pays avec un taux inférieur à 0,4 p. 100 et 11 pays avec un taux compris entre 0,5 et 1 p. 100).

Tableau 1: Perceptions gouvernementales concernant l'impact de l'accroissement naturel sur le développement, son acceptabilité et le désir d'intervenir pour changer les taux, par Commission économique, région et niveau de développement, juillet 1980

Commissions Régionales, Régions Géographiques et niveau de développement		Perceptions des gouvernements concernant l'impact de l'accroissement naturel considéré comme une entrave au développement et désir d'intervention							Total
		Taux trop bas			Taux ni trop élevés ni trop bas		Taux trop élevés		
		(A) prédominant	(B) significatif	(C) léger	pas d'entraves	(C) léger	(B) significatif	(A) prédominant	
		Taux plus élevés souhaitables			Taux plus élevés ou plus bas non souhaitables		Taux plus bas souhaitables		
		intervention globale appropriée	soutien partiel approprié		aucune intervention souhaitable		soutien partiel approprié	intervention globale appropriée	
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Région de la CEA:	Eastern Africa	-	-	1	2	6	3	4	16
	Middle Africa	*	-	2	-	3	1	-	6
	Northern Africa	1	-	-	-	1	1	3	6
	Southern Africa	-	-	-	-	-	-	4	4
	Western Africa	2	-	3	1	7	2	1	16
	Total	6	-	6	3	17	7	12	51
Région de la CEE:	Eastern Europe	2	-	3	1	-	-	-	6
	Northern Europe	-	-	3	4	-	-	-	7
	Southern Europe	-	1	2	3	3	-	-	9
	Western Europe	4	1	3	-	1	-	-	9
	Cyprus, Israel, Turkey	1	1	-	-	-	-	1	3
	North America	-	-	-	1	1	-	-	2
	USSR	-	3	-	-	-	-	-	3
	Total	7	6	11	9	5	-	1	39
Région de la CEPAL:	Caribbean	-	-	-	-	1	4	6	11
	Middle America	-	-	-	-	2	2	3	7
	Temperate S. America	2	1	-	-	-	-	-	3
	Tropical S. America	1	1	1	2	3	1	-	9
	Total	3	2	1	2	6	7	9	30

		1	2	3	4	5	6	7	Total
Région de la CEAO:	Western South Asia (part)	4	1	1	1	5	-	-	12
	Total	4	1	1	1	5	-	-	12
Région de la CEAP:	China	-	-	-	-	-	-	1	1
	Japan	-	-	-	-	1	-	-	1
	Other East Asia	2	-	-	-	-	-	1	3
	Eastern South Asia	2	-	1	1	1	-	4	9
	Middle South Asia	-	1	-	1	1	-	4	7
	Australia and New Zealand	-	-	1	-	1	-	-	2
	Melanesia	-	-	-	-	-	1	1	2
	Micronesia-Polynesia	1	-	-	-	-	2	3	6
	Total	5	1	2	2	4	3	6	23
Pays développés		6	5	1	2	7	1	-	22
Pays en développement		19	5	20	15	30	17	38	144
	Total	25	10	21	17	37	17	38	165

a/ Les noms des pays apparaissent dans le tableau annexe A.XVII.1.

Source: Informations rassemblées à partir des données de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population.

Tableau 2: Perceptions des gouvernements concernant l'impact de l'accroissement naturel considéré comme une entrave au développement, par région économique
Juillet 1980

Nombre de pays en pourcentage

Commissions Régionales et niveau de développement	Taux trop bas	Taux ni trop bas ni trop élevés	Taux trop élevés	Total
Région de la CEA	12	51	37	100
Région de la CEE	33	64	3	100
Région de la CEPAL	17	30	53	100
Région de la CEAO	42	58	-	100
Région de la CESAP	18	24	58	100
Régions développées	28	72	-	100
Régions en développement	19	37	44	100
	21	46	33	100

Tableau 3: Perceptions des gouvernements concernant l'impact de l'accroissement naturel sur le développement par Commission régionale et niveau de développement

A. Répartition en pourcentage des pays par type de perception dans des différentes Commissions Régionales

Commissions Régionales et niveau de développement	Taux trop bas	Taux ni trop élevés ni trop bas	Taux trop élevés	Total
CEA	4	55	41	100
CEE	40	56	4	100
CEPAL	14	53	33	100
CEAO	24	76	-	100
CESAP	1	9	90	100
Pays développés	36	64	-	100
Pays en développement	4	17	79	100
Total	12	29	59	100

B. Répartition en pourcentage des pays dans les différentes Commissions Régionales suivant le type de perception

Commissions Régionales et niveau de développement	Taux trop bas	Taux ni trop élevés ni trop bas	Taux trop élevés	Total
CEA	4	20	7	11
CEE	78	46	2	24
CEPAL	10	15	5	8
CEAO	2	3	-	1
CESAP	6	16	86	56
Pays développés	78	56	-	26
Pays en développement	22	44	100	74
Total	100	100	100	100

Parmi les pays en développement (où près de 80 p. 100 ont un taux d'accroissement supérieur à 2 p. 100) bien que 44 p. 100 des gouvernements estiment le taux trop élevé, 37 p. 100 cependant le considèrent comme satisfaisant et 19 p. 100 comme trop bas. Parmi les 3 pays qui ont un taux d'accroissement supérieur à 3,5 p. 100, nous trouvons un pays dans chacune de ces trois catégories. Il semble donc qu'il n'y ait pas de corrélation évidente entre la perception du taux et le niveau du taux et que les perceptions gouvernmentales ne reposent donc que partiellement sur des considérations démographiques.

Si nous considérons cette fois la relation existant entre la perception du taux d'accroissement naturel et le volume de la population (tableau 5 A et B) on constate que parmi les 36 pays de plus de 20 millions d'habitants, très peu souhaitent un taux plus élevé, 5 seulement. Les autres se partagent également entre pays satisfaits, 16, et non satisfaits parce que le taux est trop élevé, 15. Si l'on répartit les pays par niveau de développement, on note que parmi les pays développés de plus de 20 millions d'habitants, la majorité, soit 9 sur 13, sont satisfaits de leurs taux; seuls la France, la République Fédérale d'Allemagne, la RSS d'Ukraine et l'URSS souhaitent un taux plus élevé. Parmi les pays en développement de plus de 20 millions d'habitants, la proportion est inversée : 1 seul pays sur 23, l'Argentine, souhaite un taux plus élevé et 7 autres sont satisfaits de leur taux : l'Ethiopie, le Nigéria et le Zaïre en Afrique, la Colombie et le Brésil en Amérique Latine, l'Afghanistan et la Birmanie en Asie. Les 15 autres souhaitent un taux plus bas. Quant aux pays développés de moins de 5 millions d'habitants, on les retrouve aussi bien parmi les pays satisfaits que parmi les non satisfaits. Les petits pays en développement, en général, souhaitent un taux d'accroissement plus élevé ou se montrent satisfaits du taux actuel.

A. PAYS DEVELOPPES

(Pays de la CEE moins Israël, Chypre et la Turquie mais plus le Japon, l'Australie et la Nouvelle-Zélande).

Comme on pouvait s'y attendre après les remarques et la distinction déjà faites sur la répartition des perceptions par niveau de développement, c'est dans la CEE que l'on trouve la plus grande proportion de pays satisfaits, 25 pays sur 36 soit près de 70 p. 100; mais la CEE se classe aussi au deuxième rang (après les pays de la CEAO) des régions ayant la plus forte proportion de pays non satisfaits, le taux y étant estimé trop bas: 11 pays sur 36, soit 30 p.100. Parmi ces derniers, nous trouvons aussi bien des pays à économie planifiée (la Bulgarie, la République démocratique allemande, le RSS de Biélorussie, la RSS d'Ukraine, l'URSS) que des pays à économie de marché (la République Fédérale d'Allemagne, la France, le Liechtenstein, le Luxembourg et Monaco en Europe de l'Ouest) auxquels s'ajoute le Saint-Siège en Europe du Sud. Tous les autres pays d'Europe, les deux pays d'Amérique du Nord et les trois pays de la Commission pour l'Asie et le Pacifique perçoivent leur taux comme satisfaisant. Durnat la période d'observation considérée, c'est-à-dire depuis 1978, aucun pays développé n'a changé sa perception de façon radicale; cependant parmi les pays satisfaits de leur taux, quelques-uns ont modifié certains aspects de leurs politiques en réponse à l'évolution de la situation.

Tableau 4: Rapport existant entre les perceptions des gouvernements concernant l'accroissement naturel et ses taux effectifs

A. Classification des pays suivant les taux effectifs de l'accroissement naturel par niveau de développement, 1975-1980

Taux effectif moyen annuel de l'accroissement 1975-1980 Classé par catégorie	Nombre total de pays				Pays dans les régions développées				Pays dans les régions en développement				Total
	Taux plus élevés souhaitables	Taux plus élevés ou plus bas non souhaitables	Taux plus bas souhaitables	Total	Taux plus élevés souhaitables	Taux plus élevés ou plus bas non souhaitables	Taux plus bas souhaitables	Total	Taux plus élevés souhaitables	Taux plus élevés ou plus bas non souhaitables	Taux plus bas souhaitables		
0,4 et moins	7	12	-	19	7	12	-	19	-	-	-		-
0.5-0,9	5	11	-	16	4	11	-	15	1	-	-		1
1,0-1,4	5	5	10	20	-	4	-	5	5	1	10		16
1,5-1,9	2	3	6	11	-	-	-	-	2	5	6		11
2,0-2,4	6	9	12	27	-	1	-	1	6	8	12		26
2,5-2,9	4	24	11	39	-	-	-	-	4	24	11		39
3,0-3,4	5	10	15	30	-	-	-	-	5	10	15		30
3.5 et plus	1	1	1	3	-	-	-	-	1	1	1		3
Total	35	75	55	165	11	28	-	39	24	47	55		126

.../....

Rapport existant entre les perceptions des gouvernements concernant l'accroissement naturel et ses taux effectifs

B. Classification des pays suivant les taux effectifs de l'accroissement naturel par Commission régionale, 1975-1980

Taux effectif moyen annuel de l'accroissement 1975-1980 classé par catégorie	Pays dans la Région de la CEA			Total	Pays dans la Région de la CEE			Total	Pays dans la Région de la CEPAL			Total
	Taux plus élevés souhaitables	Taux plus élevés ou plus bas non souhaitables	Taux plus bas souhaitables		Taux plus élevés souhaitables	Taux plus élevés ou plus bas non souhaitables	Taux plus bas souhaitables		Taux plus élevés souhaitables	Taux plus élevés ou plus bas non souhaitables	Taux plus bas souhaitables	
0.4 et moins	-	-	-	-	7	12	-	19	-	-	-	-
0,5-0.9	-	-	-	-	5	8	-	13	-	-	-	-
1.0-1.4	2	-	1	3	-	4	-	4	2	1	5	8
1,5-1,9	-	2	1	3	-	-	-	-	1	-	1	2
2.0-2,4	2	4	4	10	1	1	1	3	-	-	4	4
2,5-2,9	2	16	5	23	-	-	-	-	1	5	3	9
3,0-3,4	-	4	7	11	-	-	-	-	1	2	4	7
3,5 et plus	-	-	1	1	-	-	-	-	-	1	c	1
Total	6	26	19	51	13	25	1	39	5	9	16	30

	Pays dans la Région de la CEAO				Pays dans la Région de la CESAP			
0,4 et moins	-	-	-	-	-	-	-	-
0,5-0.9	-	-	-	-	-	3	-	3
1.0-1.4	-	-	-	-	1	-	4	5
1,5-1,9	-	-	-	-	1	1	4	6
2,0-2,4	-	2	-	2	3	2	4	9
2,5-2,9	-	1	-	1	1	2	3	6
3,0-3,4	4	4	-	8	-	-	4	4
3,5 et plus	1	-	-	1	-	-	-	-
Total	5	7	-	12	6	8	19	33

Tableau 5: Relation entre la perception Gouvernementale concernant l'accroissement naturel et le volume de la population

A. Pays classés selon le volume de la population en 1980, par niveau de développement

Catégorie de pays selon le volume de la population 1980	Nombre total de pays				Pays développés				Pays en développement			
	Taux plus élevé désirable	Taux satisfaisant	Taux plus bas désirable	Total	Taux plus élevé désirable	Taux satisfaisant	Taux plus bas désirable	Total	Taux plus élevé désirable	Taux satis-faisant	Taux plus bas désirable	Total
0 à 0,9 million	11	12	17	40	4	3	-	7	7	9	17	33
1 à 4,9 "	9	19	9	37	-	5	-	5	9	14	9	32
5 à 9,9 "	7	18	7	32	2	7	-	9	5	11	7	23
10 à 19,9 "	3	10	7	20	1	4	-	5	2	6	7	15
20 à 49,9 "	2	10	7	19	1	5	-	6	1	5	7	13
50 et plus	5	6	8	17	3	4	-	7	-	2	8	10
Total	35	75	55	165	11	28	-	39	24	47	55	126

Relation entre la perception Gouvernementale concernant l'accroissement naturel et le volume de la population

B. Pays classés selon le volume de la population en 1980, par Commission Régionale

Catégorie de pays selon le volume de la population 1980	Pays de la Region de la CEA				Pays de la Region de la CEE				Pays de la Region de la CEPAL			
	Taux Plus élevé désirable	Taux satisfaisant	Taux plus bas désirable	Total	Taux plus élevé désirable	Taux satisfaisant	Taux plus bas désirable	Total	Taux plus élevé désirable	Taux satis-faisant	Taux plus bas désirable	Total
0 à 0,9 million	2	5	5	12	5	3	-	8	-	2	6	8
1 à 4,9 "	2	8	3	13	1	4	-	5	2	2	5	9
5 à 9,9 "	2	7	4	13	2	7	-	9	1	2	3	6
10 à 19,9 "	-	3	4	7	1	3	-	4	1	1	1	3
20 à 49,9 "	-	2	3	5	1	5	1	7	1	1	-	2
50 et plus	-	1	-	1	3	3	-	6	-	1	1	2
Total	6	26	19	51	13	25	1	39	5	9	16	30

	Pays de la Region de la CEAO				Pays de la Region de la CESAP			
0 à 0,9 million	3	1	-	4	1	1	6	8
1 à 4,9 "	1	3	-	4	3	2	1	6
5 à 9,9 "	1	2	-	3	1	-	-	1
10 à 19,9 "	-	1	-	1	1	2	2	5
20 à 49,9 "	-	-	-	-	-	2	3	5
50 et plus	-	-	-	-	-	1	7	8
Total	5	7	-	12	6	8	19	33

a) La population de la RSS de Bielorussie et de la RSS d'Ukraine est celle de 1975

Mais avant de considérer plus particulièrement ces changements et d'analyser comment les pays développés répondent aux problèmes que leur pose un taux d'accroissement perçu comme satisfaisant ou trop bas, examinons quelles sont les stratégies d'intervention les plus fréquemment utilisées.

Dans les pays développés où l'expérience des gouvernements en matière d'intervention gouvernementale est ancienne (elle remonte pour certains d'entre eux, aux années 1930), la chute des taux d'accroissement a conduit nombre d'entre eux à s'interroger sur la nécessité d'intervenir ou sur les possibilités d'améliorer l'efficacité des politiques déjà mises en oeuvre. Tous les processus sociaux et économiques qui font théoriquement partie des systèmes d'interaction complexes déterminant les tendances et niveaux du taux d'accroissement naturel, ne sont pas susceptibles également d'intervention. Il est raisonnable de penser que dans la plupart des pays, l'évolution de certains de ces processus soit, ou bien irréversible, ou bien susceptible tout au plus d'un freinage ou d'un arrêt temporaire. Parmi les processus sociaux qui semblent avoir un effet déterminant sur la fécondité, les modifications de la conditions féminine tiennent une place particulière. Cette évolution paraît irréversible. De même, la tendance à la libéralisation de la législation concernant la contraception et l'avortement peut être freinée ou temporairement arrêtée mais difficilement renversée. On peut tout au plus observer des temps d'arrêt dans cette évolution, notamment lorsque l'opinion publique exprime ses craintes devant une évolution trop rapide ou lorsque les autorités publiques s'inquiètent du fait que des changements trop radicaux de comportement individuels soient défavorables à la réalisation d'objectifs nationaux. Des réactions d'ordre moral ou religieux ont aussi été observées. Enfin, la "privatisation du mariage" illustrée par la libéralisation du divorce, l'ajournement ou le refus du mariage, conduisent à une remise en cause de cette institution et représentent également une tendance spontanée commune aux pays de l'Ouest et de l'Est que les gouvernements peuvent difficilement contrarier.

Quelles sont alors les options offertes aux gouvernements des pays développés qui considèrent leur taux d'accroissement trop bas et qui souhaitent intervenir pour le modifier ? On peut, pour les besoins de ce rapport, les regrouper en un nombre limité de catégories. Examinons tout d'abord les interventions démographiques directes. En fait, ces interventions sont d'un effet limité lorsqu'elles concernent la mortalité. Quelques résultats peuvent être obtenus dans les pays où elle est encore relativement élevée : une baisse de la mortalité infantile, par exemple, peut contribuer en quelque sorte à maximiser le nombre des naissances. Mais finalement peu de gouvernements considèrent que leur politique de mortalité et de santé n'ait d'autre objectif que celui d'assurer le bien-être des individus. Les interventions directes sur la fécondité offrent des possibilités d'action apparemment moins limitées mais elle doivent tenir compte des contraintes sociales, économiques et politiques déjà mentionnées.

Une autre option directe consiste à encourager les migrations internationales. Un double effet est attendu de l'immigration : l'absorption des immigrants dans la population s'ajoute au croît naturel de la population et les immigrants contribuent par leur fécondité relativement plus forte à relever quelque peu le niveau de la fécondité nationale.

Il peut être envisagé également d'encourager systématiquement le développement des zones d'habitat où la fécondité est plus élevée (cas des petites et moyennes

villes dans certains pays d'Europe) ou de transférer, lorsque cela est possible, des populations rurales jeunes dans les métropoles où la population est vieillissante.

Les gouvernements ont souvent recours à des interventions sur certaines variables démographiques dont l'effet attendu est surtout non démographique : par exemple, la modulation des flux des migrations internationales constitue un moyen traditionnel d'ajuster temporairement le volume et la structure de la population active aux aléas de l'économie et donc une forme de réponse à un taux d'accroissement jugé insuffisant. Un autre exemple d'intervention de ce type est fourni par les pays qui tentent de redistribuer de façon optimale sur l'ensemble de leur territoire les ressources humaines disponibles. C'est le cas des pays d'Europe de l'Est où la participation des femmes à l'activité économique est déjà très élevée et le recours à l'immigration étrangère est limité.

Enfin, les actions consistant à adapter l'appareil économique aux évolutions du volume et de la structure de la population sont bien entendu d'intérêt majeur. La sélection de taux de croissance de l'économie, mais aussi le choix d'un certain type de croissance, constituent des réponses structurelles aux problèmes posés par la croissance démographique. En complément de ces réponses structurelles, on peut signaler aussi le recours fréquent à des mesures socio-économiques qui ont un lien direct avec les fluctuations de la population active : par exemple, les modifications de l'âge à la retraite, de la durée du travail, etc.

A la lumière de ces considérations générales sur les options offertes aux gouvernements des pays développés, considérons maintenant de façon plus spécifique les problèmes auxquels ils sont confrontés et les réponses qu'ils y apportent. Le tableau 6 indique que quelques pays européens seulement ont modifié leurs politiques depuis 1978, tout en continuant de considérer leur taux actuel d'accroissement comme satisfaisant. A l'exception de la Pologne qui se montre satisfaite de l'évolution spontanée de son taux, les autres pays qui ont modifié leur position l'ont fait dans le sens d'un renforcement de leurs politiques en vue de maintenir le taux à son niveau actuel. La situation démographique des pays développés est assez homogène et ne présente que peu ou pas de différence entre les pays qui considèrent leur taux d'accroissement comme trop bas ou comme satisfaisant. La différence de perception semble plutôt liée dès lors à des appréciations divergentes sur les conséquences socio-économiques des tendances démographiques. Nous considérons donc ensemble les pays satisfaits et non satisfaits mais qui, à des degrés divers, ont pris des mesures pour augmenter ou maintenir leur taux. Parmi les pays développés, la Pologne en Europe de l'Est, le Danemark, l'Islande, la Norvège et le Royaume-Uni en Europe du Nord, l'Espagne le Portugal et la Yougoslavie en Europe du Sud et les Etats-Unis ne souhaitent pas intervenir pour modifier ou maintenir leurs taux : ils font confiance aux mécanismes spontanés d'évolution du taux.

Les pays de l'Est comme ceux de l'Ouest ont connu une baisse considérable de la fécondité à partir des années 1960; certains d'entre eux ont cependant mieux résisté (Yougoslavie, Albanie, Pologne) ce qui explique la satisfaction qu'ils expriment à l'égard de leur taux actuel d'accroissement de la population et de ses tendances. 4/ Récemment, un certain nombre de pays de l'Europe de l'Est

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4/ E. Brennan et J-C. Chasteland, "Les politiques de population dans les pays socialistes d'Europe et du Tiers Monde; Communication au Colloque Malthus, Paris, 27-29 mai 1980. Miméographié.

Tableau 6: Changements dans les perceptions des gouvernements concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux, juillet 1978 - juillet 1980

Pays situés dans la Région de la CEE

	Perceptions des gouvernements concernant l'impact de l'accroissement naturel considéré comme une entrave au développement et désir d'intervention							
	Taux trop bas Impact des entraves:			Taux ni trop élevés ni trop bas		Taux trop élevés Impact des entraves:		
	(A) prédominant	(B) significatif	(C) léger	pas d'entraves	(C) léger	(B) significatif	(A) prédominant	Total
	Taux plus élevés souhaitables			Taux plus élevés ou plus bas non souhaitables		Taux plus bas souhaitables		
	intervention globale appropriée	soutien partiel approprié		aucune intervention souhaitable		soutien partiel approprié	intervention globale appropriée	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Nombre de pays dans chaque catégorie en 1978	7	6	7	12	6	-	1	39
Changements dans les perceptions concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux durant la période 1978-1980	b	b		-Czechoslovakia -Hungary -Romania -Belgium	-Poland	b	b	
			+Czechoslovakia +Hungary +Romania +Belgium	+Poland		b	b	
Nombre de pays dans chaque catégorie en 1980	7	6	11	9	5	-	1	39

b) Pas de changement
(+) Pays entrant dans cette catégorie
(-) Pays changeant de catégorie

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

parmi les plus affectés par cette baisse, ont vu leur fécondité remonter légèrement (Hongrie, Roumanie et Tchécoslovaquie) et par conséquent ces gouvernements, tout en restant très vigilants à l'égard de l'évolution future de leur taux, continuent à se déclarer satisfaits de leur taux d'accroissement. Faut-il rappeler que dans plusieurs pays de l'Est, comme la Roumanie par exemple, le gouvernement a restreint l'accès aux méthodes contraceptives modernes sans l'interdire à proprement parler, et a limité très strictement les indications légales autorisant l'avortement. 5/ Les réactions à la baisse du taux d'accroissement dans les pays d'Europe occidentale sont beaucoup moins homogènes. 6/ Ainsi la France, dont le taux de natalité reste relativement élevé par rapport à la plupart des autres pays développés et dont le potentiel d'accroissement lié à la structure par âge devrait lui permettre d'envisager son accroissement futur avec un certain optimisme, compte cependant parmi les premiers pays à avoir pris un ensemble de mesures en vue de renverser la tendance. Le gouvernement de la République Fédérale d'Allemagne dont la population est déjà en décroissance se déclare non satisfait de son taux mais ne paraît pas, par contre, disposé à mettre en oeuvre une politique pronataliste. Cependant, dans un récent discours sur la politique générale du gouvernement, le Chancelier Helmut Schmidt invitait "toutes les forces sociales du pays à se montrer mieux disposées vis-à-vis de l'enfant et à agir de façon à faciliter la vie des familles avec enfants." 7/

Le déclin du taux d'accroissement naturel de la population, et la décroissance de la population, ont créé des problèmes de main-d'oeuvre dans la plupart des pays développés. Les pays à économie de marché ont pallié en partie ce manque de main-d'oeuvre en faisant appel à l'immigration de travailleurs étrangers. Aux effets économiques immédiats que représente cette entrée d'immigrants, s'ajoute un effet non négligeable sur le plan démographique : leur fécondité plus élevée que celle des autochtones, contribue à relever le taux d'accroissement de la population dans les pays d'accueil. C'est ainsi par exemple qu'au Luxembourg, pays européen connaissant actuellement la natalité la plus basse (les décès excèdent les naissances chaque année depuis 1972), on estime que sans les naissances dues à la présence de nombreux immigrés, c'est depuis 1966 que les décès auraient été plus nombreux. En 1974, le taux de natalité de la population luxembourgeoise s'élevait à 8,5 p. 1000 et son taux de mortalité à 14,3 p. 1000 (taux d'accroissement naturel : -0,58 p. 100) ; le taux de natalité des étrangers résidant dans le pays s'élevait la même année à

5/ En dehors des dispositions légales autorisant l'avortement pour motif de santé ou pour sauver la vie de la mère, l'avortement n'est plus autorisé que si la femme est âgée de plus de 45 ans ou si elle a 4 enfants à charge. L'approbation d'un comité médical est requise dans tous les cas.

6/ C. Alison McIntosh, Population Policy in the Liberal Democracies: A Comparative Study of France, Sweden and West Germany. Unpublished Phd. Dissertation, Center for Population Planning, University of Michigan, 1980.

7/ Detrev B. Rein; "Policy Concepts relevant to the Population in the Federal Republic of Germany", 4th European Population Seminar, Athens, 2-5 October 1979.

19,1 p. 1000 et le taux de mortalité à 4,8 p. 1000 (taux d'accroissement naturel : 1,43 p. 100). 8/ En France, plus de 10 p. 100 9/ des enfants nés en 1978 sont issus de familles dont les deux parents ou un seul sont étrangers. 10/ L'effet sur le taux de fécondité en tant que telle est plus faible mais il n'est pas négligeable lorsqu'on connaît les faibles niveaux de fécondité observés parmi les nationaux de ces pays. On a calculé ainsi qu'en France et en République Fédérale d'Allemagne cette contribution représenterait environ 5 p. 100 de l'indice synthétique de fécondité.

Mais un recours systématique à l'immigration étrangère pour pallier d'une part, certains problèmes de main-d'oeuvre et d'autre part, de croissance démographique n'est pas sans susciter sur le plan social, des réticences de l'opinion publique et sur le plan démographique, des doutes quant à son efficacité à long terme.

Si les comportements démographiques de la population étrangère en matière de fécondité contribue au maintien ou à l'accroissement de la population globale, le phénomène ne peut jouer que de façon temporaire car on sait que ces comportements tendent à s'aligner à plus ou moins longue échéance sur ceux de la population nationale.

Il nous reste encore à examiner, parmi les gouvernements qui ont décidé d'intervenir, ceux qui optent pour une politique d'intervention globale et ceux qui préfèrent n'apporter qu'un soutien partiel à leur intervention.

Parmi les 11 pays développés qui souhaitent un taux d'accroissement naturel plus élevé, 6 ont décidé de mettre en oeuvre une politique d'intervention globale, pays à économie de marché aussi bien que pays à économie planifiée. Les interventions sont multi-dimensionnelles et portent à la fois sur les facteurs démographiques et sur les facteurs socio-économiques. Tous ont des politiques dans le domaine de la fécondité : l'objectif immédiat est de l'augmenter de façon à augmenter aussi le niveau d'accroissement naturel, mais ces politiques recèlent en même temps des mesures destinées à améliorer le bien-être individuel. Ainsi les mesures d'incitation financières (prestations familiales et abattement d'impôt sur le revenu) sont destinées à encourager la venue d'un enfant supplémentaire, mais aussi à donner aux familles une compensation pour les dépenses occasionnées par l'élevage des enfants. La mortalité dans les pays développés est plus rarement considérée pour ses effets potentiels sur le taux d'accroissement, du fait qu'elle a déjà atteint des niveaux très bas. Le rôle donné aux interventions sur la mobilité spatiale interne est d'autant plus important que le recours aux migrations internationales est limité, ce qui est le cas des pays à économie planifiée. Par contre ce moyen d'action reste, pour des raisons évidentes liées à la taille du pays, inexistant au Luxembourg, Monaco,

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8/ "Un exemple à ne pas suivre". Population et Sociétés, No 95 décembre 1976. Bulletin mensuel d'information démographique, économique et sociale; Editions de l'Institut nationale d'études démographiques.

9/ Il s'agit du rapport du nombre de naissances légitimes d'étrangers au nombre total de naissances observées en France.

10/ Situation démographique de la France, Population No 4-5 juillet-octobre 1980, éditions de l'Institut national d'études démographiques.

Liechtenstein. Le Luxembourg a fait appel, inversement beaucoup plus à l'immigration, comme les autres pays à économie de marché. Mais la crise économique qui sévit depuis ces dernières années a freiné et même arrêté l'immigration des travailleurs étrangers. La politique d'immigration de pays comme la France par exemple s'oriente plutôt sur l'entrée des familles de travailleurs déjà établis sur son territoire et qu'elle veut conserver, ou sur l'accueil de réfugiés.

Les 5 autres pays souhaitant un taux d'accroissement plus élevé et les 19 pays satisfaits de leur taux, mais qui restent attentifs à son évolution, ont décidé de mettre en oeuvre une politique de soutien partiel. Dans la plupart des cas, l'intervention gouvernementale reste multi-dimensionnelle, particulièrement dans les pays à économie planifiée, mais elle est appliquée avec moins d'intensité et avec une finalité qui peut être différente : l'aspect du bien-être individuel l'emportera sur l'aspect démographique dans les mesures prises dans le domaine de la fécondité; les interventions sur la distribution spatiale, les migrations internationales et les changements de structure socio-économique jouent un rôle important mais non plus essentiel.

Plusieurs gouvernements, particulièrement en Europe de l'Est, soucieux d'augmenter leur taux d'accroissement, ou tout au moins de le maintenir à son niveau actuel, ont précisé le sens de leur intervention en indiquant les objectifs souvent sous forme implicite, qu'ils se proposaient d'atteindre (cf. tableau 7). En Bulgarie, le gouvernement met l'accent sur l'aspect collectif et individuel de sa politique démographique : atteindre un niveau de croissance plus élevé et plus stable; la naissance et l'élevage d'un plus grand nombre d'enfants dans la famille, 2 à 3, est un objectif national de toute première importance à la fois pour le développement du pays et pour la consolidation de la famille elle-même. Le Gouvernement hongrois s'efforce de développer parmi sa population le concept de la famille de 3 enfants, et veut augmenter la fécondité afin d'atteindre un taux net de reproduction égal à l'unité. Le gouvernement de la République Démocratique Allemande souhaite que les familles aient au moins 2 enfants, et celui de la Roumanie se fixe un taux d'accroissement égal à 1,1 p. 100 de manière à ce que le volume de la population s'élève à 24 ou 25 millions en 1990 et 30 millions en 2000. Dans les autres régions de l'Europe, la France a fixé comme objectif un taux de fécondité égal ou légèrement supérieur à celui qui est requis pour assurer le remplacement des générations, la Grèce, un taux net de reproduction supérieur à l'unité. En Finlande, le gouvernement déclare que la population ne devrait diminuer dans aucune région du pays et que le taux net de reproduction devrait augmenter. Quant au Japon, l'objectif fixé est la stationnarité de la population.

B. PAYS EN DEVELOPPEMENT

Dans les pays en développement, le maintien à un haut niveau des taux de reproduction nets, les soldes positifs croissants des naissances par rapport aux décès, l'aggravation des rapports de dépendance déjà très élevés, en même

Tableau 7: Objectifs gouvernementaux de croissance

	Objectifs exprimés sous forme explicite d'indicateurs démographiques a/								Objectifs exprimés sous forme implicite
	Taux de croissance	Taux d'accroissement naturel	Taux brut de natalité	Taux de fécondité	Taux brut de reproduction	Taux net de reproduction	Nombre d'enfants par femme	Nombre d'enfants par famille	Taille de la population
Commission économique pour l'Afrique									
Afrique méridionale									
Lesotho	2,0% (pas de date)								
Afrique occidentale									
Ghana	1,8% en 2000								
Afrique orientale									
Kenya	3,0% en 1980 2,8% en 2000								
Maurice			22,5 o/oo dans les années 1980		1,12 en 1982-87				
Afrique septentrionale									
Egypte		10,6 o/oo en 1982	23,6 o/oo en 1982						Parvenir à une taille de la population de 41 millions en 1982
Tunisie	1,0% en 2000		32,3 o/oo en 1981 29,9 o/oo en 1986						
Maroc			35 o/oo en 1985						

a/ Traduction non officielle de documents publiés en anglais et en espagnole

	Objectifs exprimés sous forme explicite d'indicateurs démographiques									Objectifs exprimés sous forme implicite
	Taux de croissance	Taux d'accroissement naturel	Taux brut de natalité	Taux de fécondité	Taux brut de reproduction	Taux net de reproduction	Nombre d'enfants par femme	Nombre d'enfants par famille	Taille de la population	
Commission régionale pour l'asie										
Asie orientale										
Chine		5 o/oo en 1985 0 o/oo en 2000						1		
Japon										Population stationnaire considérée désirable et prévue
Asie méridionale centrale										
Bangladesh	1,5 % en 1980 1,5 o/oo en 1985						2,6			
Inde						1 en 2000 partout dans le pays				
Iran 1/	1,9% en 1982		30,e/oo en 1982							
Népal	1,0% en 1985		38 o/oo en 1979-80							
Pakistan	2,5% en 1982-83		35,5 o/oo en 1982-83							
Sri Lanka			25,0 o/oo en 1980							

1) Situation avant le changement de gouvernement

	Objectifs exprimés sous forme explicite d'indicateurs démographiques									Objectifs exprimés sous forme implicite
	Taux de croissance	Taux d'accroissement naturel	Taux brut de natalité	Taux de fécondité	Taux brut de reproduction	Taux net de reproduction	Nombre d'enfants par femme	Nombre d'enfants par famille	Taille de la population	
Asie orientale méridionale										
Indonésie	2% en 1979-84		34 o/oo en 1984							
Malaisie	2% en 1985		28,2 o/oo en 1980							
Philippines	2,3% en 1980					1 en 2000				
	2,0 % en 1985									
République de Corée	1,6% en 1981	En dessous de 1,5% dans les années 1980								
Singapour	0 % en 2000					1 (à maintenir)		2		
Viet Nam	2,% en 1980									
	1,5% en 1985									
	1,0% en 2000									
Thaïlande	2,1% en 1981									
Mélanésie										
Papouasie-Nouvelle Guinée	2,5% (pas de date)									
Micronésie-Polynésie										
Fidji			22,0 o/oo en 1980							

	Objectifs exprimés sous forme explicite d'indicateurs démographiques									Objectifs exprimés sous forme implicite
	Taux de croissance	Taux d'accroissement naturel	Taux brut de natalité	Taux de fécondité	Taux brut de reproduction	Taux net de reproduction	Nombre d'enfants par femme	Nombre d'enfants par famille	Taille de la population	
Commission régionale pour l'Europe										
Europe occidentale										
France										1975 - Objectif adopté par le Conseil français de la planification économique: Un niveau de fécondité proche et de préférence légèrement au-dessus de celui nécessaire pour assurer le remplacement des générations
Europe de sud										
Grece	pas en dessous de 1%					Au-dessus de 1				
Europe orientale										
Bulgarie										L' objectif du pays est d'atteindre des taux de croissance de la population plus élevés et plus stables
Hongrie										On estime que la naissance et l'élevage d'un nombre plus élevé d'enfants dans la famille (2 ou 3) est un objectif national de première importance à la fois pour le développement du pays et la consolidation de la famille elle-même
Rep. Démocratique Allemande										Promouvoir l'idéal de la famille de 3 enfants. Augmenter la fécondité pour atteindre un taux net de reproduction égal à l'unité. Avoir au moins 2 enfants ce qui assurerait le remplacement de la population.

	Objectifs exprimés sous forme explicite d'indicateurs démographiques									Objectifs exprimés sous forme implicite
	Taux de croissance	Taux d'accroissement naturel	Taux brut de natalité	Taux de fécondité	Taux brut de reproduction	Taux net de reproduction	Nombre d'enfants par femme	Nombre d'enfants par famille	Taille de la population	
Roumanie		1,1%							Parvenir à une taille de la population de 24 à 25 millions en 1990 et 30 millions en 2000.	
Europe septentrionale										
Finlande										La population ne doit diminuer dans aucune région du pays - Le taux net de reproduction devrait augmenter - Si changement de tendance, attention plus grande
Commission régionale pour l'Amérique Latine										
Caraïbes										
Trinité-et-Tobago			15,5 o/oo en 1980							
Amerique centrale										
El salvador	2,9% en 1982		40,2 o/oo en 1982							
Mexique	2,5% en 1982 1,0% apres 2000									
Amérique du Sud tempérée										
Argentine									Atteindre une taille de la population de 40 à 50 millions en 2000.	

Sources

- Reponses à la quatrième enquête démographiques auprès des gouvernements en 1978
  Examen et évaluation du plan d'action mondial sur la population
- Objectifs formulés dans les plans nationaux de développement
- Publications nationales officielles
- Population Headliners, No.66 September 1980; Division of Population, Economic and Social Commission for Asia and the Pacific, United Nations, Bangkok, Thailand.

a) Date de formulation de l'objectif

La plupart des pays qui ne sont pas mentionnés dans la liste ci-dessous ont fait part de leur objectif dans leur réponses à la quatrième enquête démographiques des Nations Unies

Afrique:

Ghana	Plan de développement	1973-1978
Kenya	Plan de développement	1979-1983
Egypte	1978	
Maroc	Plan de développement	1973-1977

Asie:

Chine	1979	
Inde	1979	
Indonesie	Plan de développement	1979-1984
Nepal	Plan de développement	1975-1979
Pakistan	Plan de développement	1978-1983
Malaisie	Plan de développement	1976-1980
Philippines	Plan de développement	1978-1982
Rep. de Corée	Plan de développement	1977-1981
Singapour	1980	
Viet Nam	Plan de développement	1976-1980
Thailande	Plan de développement	1977-1981
Fidji	Plan de développement	1976-1980

Amerique latine:

Trinite-et-Tobago:	National Family Planning Progrem for 1968-1972
El Salvador	1977
Mexique	1977

Europe:

Bulgarie:	Réponse à la troisième enquête des Nations Unies auprès des gouvernements: Politiques de population dans le contexte du développement en 1976

temps que l'accroissement de la population active, conduisent de nombreux gouvernements à exprimer leur insatisfaction sur les niveaux et les tendances des taux d'accroissement. Rappelons que 37 p. 100 seulement des pays sont satisfaits du taux d'accroissement de la population et 63 p. 100 sont non satisfaits dont 19 p. 100 parce que le taux est trop bas et 44 p. 100 parce qu'il est trop élevé.

Au niveau régional, c'est dans la CESAP que l'insatisfaction est la plus grande puisque 19 pays sur 30 (rappelons que le Japon, l'Australie et la Nouvelle-Zélande sont inclus dans le groupe des pays développés) représentant 63 p. 100 des pays désirent un taux plus bas; puis dans la CEPAL : 16 pays sur 30, soit 53 p. 100 des pays et dans la CEA : 19 pays sur 51, soit 37 p. 100. Aucun pays de la CEAO ne souhaite un taux plus bas. Les régions qui regroupent le plus de pays satisfaits sont la CEAO, 7 pays sur 12 soit 58 p. 100 des pays, suivie de la CEA, 26 pays soit 51 p. 100; la CEPAL en regroupe 9 soit 30 p. 100 et la CESAP, 5 seulement soit 17 p. 100.

C'est dans la CEAO que la proportion de pays désirant un taux plus élevé est la plus importante; 5 pays soit 42 p. 100, puis, et presque sur le même pied, dans la CESAP, 6 pays soit 20 p. 100, la CEPAL, 5 pays soit 17 p. 100 et la CEA, 6 soit 12 p. 100 (cf. tableau 1 et 2).

Une analyse tenant compte de la taille des populations, montre que l'écart entre la distribution des perceptions par rapport aux régions s'accentue plus nettement que dans l'analyse par pays. Si 73 p. 100 de la population de la CEAO résident dans des pays satisfaits de leur taux d'accroissement, ce qui représente 3 p. 100 de la population mondiale résidant dans des pays satisfaits, 90 p. 100 de la population de la CESAP résident dans des pays non satisfaits du taux estimé trop élevé, mais représentent 86 p. 100 de la population mondiale (cf. tableau 3). Comme on l'avait déjà constaté lors de l'examen par niveau de développement, l'accentuation de l'écart entre la distribution des perceptions par région est causée par le poids considérable des grands pays d'Asie qui tous souhaitent un taux d'accroissement plus bas.

Entre 1978 et 1980, quelques pays en développement ont changé leur perception de façon notable, plus nombreux sont ceux qui ont renforcé leurs politiques en vue de modifier les niveaux d'accroissement naturel jugés non satisfaisants. Nous suivrons le même plan d'analyse que pour les pays développés et avant donc de considérer de façon systématique les changements de perceptions et de politiques, examinons les stratégies d'intervention dont disposent les pays en développement.

Dans les pays en développement, les variations dans l'étendue et l'intensité des interventions gouvernementales reflètent la plus grande variété des situations démographiques que dans les pays développés. Certains pays ont entamé la dernière phase de leur transition démographique alors que d'autres ont à peine entamé la première : des taux d'accroissement naturel s'échelonnant de plus de 3 p. 100 à 1 p. 100 sont fréquemment observés. Ajoutons à cela des conditions économiques, sociales et politiques qui elles aussi varient considérablement et donc influent fortement sur les possibilités d'action gouvernementale. Comme nous le verrons, les priorités données à certaines options sont ainsi souvent très différentes de celles des pays développés. Nous avons regroupé ces différentes options dans les

mêmes catégories que celles utilisées pour les pays développés.

Parmi les options politiques offertes aux pays en développement, les interventions directes sur la mortalité et la fécondité sont les plus fréquemment retenues. Examinons tout d'abord l'effet des variations du niveau de la mortalité sur le choix de ces options. Il n'est pas dans notre propos d'examiner ici les stratégies adoptées par les pays en développement pour abaisser le niveau de la mortalité - celle-ci fait l'objet d'un chapitre particulier - mais d'indiquer le rôle démographique assigné aux interventions sur la mortalité dans certains pays. Il est bien entendu que tous les gouvernements des pays en développement considèrent aussi que la baisse de la mortalité et l'amélioration de la santé qui la conditionne sont une fin en soi. Cependant, pour certains de ces pays qui jugent leur taux d'accroissement trop bas, ou même satisfaisant, et dont la mortalité est élevée, la baisse de celle-ci est considérée comme un moyen de maintenir ou de relever le taux d'accroissement. En revanche, pour des pays plus nombreux qui estiment souhaitable de réduire leur taux d'accroissement et donc leur fécondité, la baisse de la mortalité est perçue comme constituant une condition préalable à une modification ultérieure du comportement procréateur des couples.

Entretemps, l'abaissement de la mortalité, avec ses effets sur le taux d'accroissement, conduit nombre de gouvernements à intervenir directement sur la fécondité. Cette intervention peut répondre à un objectif démographique et simultanément améliorer le bien-être individuel. Les expériences récentes ont montré que les interventions en matière de fécondité n'avaient de chance de connaître de succès que si elles s'intégraient dans un ensemble de mesures tendant à améliorer le niveau de vie. Un autre mode d'intervention direct, dont les effets démographiques sont relativement faibles, reste offert aux gouvernements et consiste à recourir aux migrations internationales. Pour la plupart des pays, l'effet des migrations est marginal et celles-ci sont donc rarement utilisées à cette seule fin. En revanche, les modifications de la distribution spatiale de la population, dans les pays où les niveaux globaux de fécondité et de mortalité sont élevés et connaissent encore des disparités régionales importantes, peuvent jouer un rôle significatif dans l'évolution des taux d'accroissement.

Certaines des interventions sur les variables démographiques peuvent avoir un effet indirect dans le domaine socio-économique estimé par certains gouvernements plus important que l'effet démographique direct. C'est ainsi que nombre de pays considèrent que l'amélioration de la morbidité et la réduction de la mortalité constituent une contribution importante à l'accroissement de la productivité de la population active. Une meilleure répartition géographique de la population peut contribuer également, de façon très importante, à la résolution de problèmes posés par un taux de croissance naturel non satisfaisant en permettant une utilisation optimale des ressources humaines et naturelles. C'est d'ailleurs une des priorités de l'action gouvernementale des pays en développement. Enfin, les migrations internationales peuvent contribuer de leur côté à apporter des solutions temporaires aux problèmes de l'emploi, de la balance des paiements, etc.

Parmi les options non démographiques, la réalisation de changements internes plus ou moins radicaux dans l'organisation économique, sociale et technologique de

la société, en un mot dans le choix des stratégies de développement, constitue pour de nombreux gouvernements un facteur déterminant d'une part, du succès de leur politique de population, et d'autre part, de leur capacité à répondre aux problèmes posés par le taux d'accroissement naturel. Indiquons également que certains gouvernements attachent une certaine importance à la modification du système des relations économiques internationales pour résoudre une partie des problèmes démographiques déjà mentionnés.

Considérons maintenant, de façon plus spécifique, et région par région, les perceptions gouvernementales concernant l'accroissement de la population, les changements survenus depuis 1978 et les options d'intervention choisies pour maintenir ou modifier des taux jugés non satisfaisants.

CEA

Six pays (la République centrafricaine, la Guinée équatoriale, le Gabon, Jamahiriya arabe libyenne, la Guinée et la Côte d'Ivoire) perçoivent le taux d'accroissement comme étant trop bas, 26 l'estiment satisfaisant et 19 le perçoivent comme étant trop élevé (cf. tableau 1). Depuis 1978 quelques pays ont changé radicalement leur perception alors que d'autres, plus nombreux, ont ajusté leurs politiques (cf. tableau 8). Le Mozambique, qui en 1978 estimait son taux d'accroissement trop bas, le considère aujourd'hui comme satisfaisant. L'évolution de la fécondité et de ses incidences sur la croissance de la population présente pour ce pays un élément majeur de sa politique démographique et il désire au moins la maintenir à son niveau actuel.

La République-Unie du Cameroun, qui elle aussi estimait en 1978 son taux d'accroissement naturel trop bas le considère maintenant trop élevé. Le parti de l'Union Nationale Camerounaise dans le rapport publié suite au IIIème Congrès ordinaire tenu à Bafoussam (République-Unie du Cameroun) en février 1980 déclare dans les résolutions de politique sociale et culturelle qui servent de directives aux politiques gouvernementales"... considérant qu'une évolution démographique harmonieuse conduit à une meilleure maîtrise des facteurs de développement, notamment au niveau des familles et des emplois... exhorte le gouvernement à prendre les mesures adéquates en vue d'aider les populations camerounaises à assurer les conséquences de la croissance démographique de manière à continuer à développer les conditions favorables à leur épanouissement". 11/

Quant à l'Algérie qui en 1978 percevait son taux comme satisfaisant, le considère maintenant trop élevé. Le Comité central du Front de Libération National, lors de sa deuxième session ordinaire tenue du 2 au 30 décembre 1979, a adopté la recommandation suivante: "les actions d'information et d'éducation sanitaire ainsi que la protection maternelle et infantile et la mise en oeuvre d'une politique démographique fondée sur l'adhésion individuelle et conforme à nos valeurs socio-culturelles doivent être prises en charge, développées et facilitées..." et "considère que le rythme de croissance de la population, s'il se maintenait, constituerait une lourde charge pour l'économie, limitant par la même tous les efforts de développement et d'amélioration des conditions de vie des citoyens".Le Comité central a adopté également une résolution concernant la

11/ Cameroon Tribune, 29 février 1980 (Yaoundé, République-Unie du Cameroun).

Tableau 8: Changements dans les perceptions des gouvernements concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux, juillet 1978 - juillet 1980

Pays situés dans la région de la CEA

	Perceptions des gouvernements concernant l'impact de l'accroissement naturel considéré comme une entrave au développement et désir d'intervention							
	Taux trop bas — Impact des entraves: (A) prédominant	(B) significatif	(C) léger	Taux ni trop élevés ni trop bas — pas d'entraves	(C) léger	Taux trop élevés — Impact des entraves: (B) significatif	(A) prédominant	Total
	Taux plus élevés souhaitables — intervention globale appropriée	soutien partiel approprié	Taux plus élevés ou plus bas non souhaitables — aucune intervention souhaitable			Taux plus bas souhaitables — soutien partiel approprié	intervention globale appropriée	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Nombre de pays dans chaque catégorie en 1978	8	-	3	4	19	3	13	50
Changements dans les perceptions concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux durant la période 1978-1980	- Mozambique - U. Rep. of Cameroon	b	b	- Algeria - Benin - Mali	- Zambia - Nigeria		- Rwanda	
	b	b	+ Mozambique + Benin + Mali	+ Zambia + Nigeria		+ Rwanda + U. Rep. of Cameroon + Algeria + Zimbabwe a/		
Nombre de pays dans chaque catégorie en 1980	6	-	6	3	17	7	12	51

a/ Les pays soulignés sont devenus Etats-Membres des Nations Unies ou de ses agences spécialisées durant la période 1978-1980

b) Pas de changement

(+) Pays entrant dans cette catégorie

(-) Pays changeant de catégorie

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

nécessité de parvenir "à une définition et à une mise en oeuvre d'une politique de maîtrise de la croissance démographique en étroite collaboration avec les possibilités de notre économie nationale et les objectifs d'amélioration des conditions de vie et de satisfaction des besoins sociaux". 12/

Les changements survenus dans les autres pays de la région, consistent uniquement en une adaptation des politiques gouvernementales en réponse à l'évolution de la situation, mais sans changement de perceptions.

Le Bénin et le Mali, de même que la Zambie et le Nigéria perçoivent toujours leur taux comme satisfaisant, mais alors que les deux premiers pays mentionnés interviennent de façon partielle en vue de maintenir les tendances spontanées du taux, les deux autres sont confiants en son évolution. A la lumière d'informations plus récentes, on considère maintenant que le Gouvernement du Rwanda mène une politique d'intervention partielle en vue d'abaisser son taux d'accroissement; le Zimbabwe, 13/ pays ayant accédé récemment à l'indépendance a été classé dans la même catégorie.

Les 6 pays africains qui souhaitent un taux d'accroissement plus élevé ont tous mis en oeuvre une politique d'intervention globale pour atteindre cet objectif. Jamahiriya arabe libyenne, la Guinée, la Côte d'Ivoire et le Gabon font porter leur action conjointement sur la mortalité, la fécondité, la distribution spatiale de la population et la migration internationale tout en s'efforçant de changer les conditions socio-économiques qui influeront à leur tour sur certains aspects du comportement démographique de leur population. La Guinée équatoriale agit sur tous ces facteurs mais ne veut pas intervenir dans le domaine de la fécondité, tandis que la République centrafricaine 14/ estime qu'une action sur la distribution spatiale et sur les facteurs socio-économiques devrait être suffisante pour amener le taux d'accroissement à un niveau plus élevé,considéré comme nécessaire dans l'optique de développement.

Parmi les 26 pays qui se déclarent satisfaits du niveau actuel de leur taux, 3 seulement (Somalie, Zambie et Nigéria) estiment les tendances spontanées de ce taux satisfaisantes et ne prennent donc aucune mesure, contrairement aux 23 autres pays dont les gouvernements ont décidé de mettre en oeuvre une politique partielle d'intervention en vue de maintenir le taux à son niveau actuel.

Douze parmi les 19 pays souhaitant un taux d'accroissement naturel plus bas ont une politique d'intervention globale. Les mesures gouvernementales portent sur la plupart des variables démographiques, mais l'accent est mis sur la fécondité et la mortalité. Tous considèrent que le changement des conditions socio-économiques entraînera également une modification des comportements démographiques.

12/ Moudjahedine, 1er et 6 janvier 1980 (Alger. Algérie)

13/ Le Zimbabwe n'a pas encore exprimé officiellement sa position ni ses positions démographiques.

14/ Situation en 1978.

Parmi ces pays certains ont fixé des objectifs à leur politique démographique par la détermination d'indicateurs démographiques, précisant les buts à atteindre dans des délais de temps impartis (cf. tableau 7). Ceux qui l'ont fait sont des pays désireux de voir baisser leur taux d'accroissement et ce sont en général des pays déjà bien engagés dans le processus de la transition démographique. Le Kenya s'est fixé un taux de croissance de 3 p. 100 à atteindre cette année et de 2,8 p. 100 en 2000; l'île Maurice voudrait que son taux de natalité se situe à 22,5 p. 1000 durant les premières années de 1980, et son taux brut de reproduction à 1,12 durant la période 1982-1987. En Afrique du Nord, l'Egypte a déterminé ses objectifs pour l'année 1982 : un taux d'accroissement naturel de 10,6 p. 1000 (taux de natalité de 23,6 p. 1000) de façon à atteindre une population de 41 millions d'habitants. La Tunisie veut atteindre un taux de croissance de 1 p. 100 en 2000; les étapes de sa stratégie sont planifiées : un taux de natalité de 32,3 p. 1000 en 1981 et de 29,9 p. 1000 en 1986. Le Lesotho veut atteindre un taux de croissance de 2 p. 100 mais aucun délai n'est mentionné et le Ghana un taux de 1,8 p. 100 en 2000.

CEPAL

La moitié des pays (16 sur 30) considère le taux d'accroissement naturel comme trop élevé (cf. tableau 1 et 9). Ce sont les mêmes pays que ceux que nous trouvions déjà en 1978 auxquels s'ajoutent 3 nouveaux venus : Dominique, Sainte-Lucie et Saint-Vincent-et-Grenadines 15/ Costa Rica a renforcé les mesures qu'il avait déjà prises afin de réduire son taux. Le Gouvernement de Costa Rica avait déjà pris des mesures démographiques dans le domaine de la fécondité et de la migration internationale: il a adopté maintenant un ensemble de mesures dans le domaine de la distribution spatiale : le gouvernement voudrait freiner les déplacements internes de la population particulièrement en direction des centres urbains et en même temps restructurer la configuration rurale et urbaine du pays. Cinq pays souhaitent au contraire un taux plus élevé: ce sont les 4 pays qui avaient déjà cette perception en 1978, l'Argentine, l'Uruguay, la Bolivie et le Paraguay, auxquels est venu se joindre le Chili qui se déclarait satisfait de son taux en 1978. Une déclaration de l'Office national chilien de la planification en 1979 faisait état de la nécessité d'avoir une politique nationale pronataliste : "une augmentation substantielle de la population est jugée désirable en vue de renforcer la sécurité nationale et d'accroître le développement économique". 16/ En Argentine surtout, et dans une moindre mesure en Uruguay et en Bolivie, les gouvernements mettent en oeuvre une politique d'intervention globale : politique multi-dimensionnelle agissant sur la mortalité, la fécondité, les déplacements internes de la population et la configuration rurale et urbaine en Argentine et en Bolivie, les déplacements internes et la configuration urbaine seulement en Uruguay, la migration internationale et sur les facteurs socio-économiques. L'Argentine encourage particulièrement l'immigration, mais le gouvernement ne cache pas qu'il préférerait que l'augmentation de la population se fasse surtout à partir de son propre accroissement, tout en réalisant que le pays n'atteindra pas un taux

15/ Ces pays n'ont pas encore exprimé officiellement leur position à l'égard des politiques démographiques.

16/ Oficina de Planificación Nacional (ODE PLAN) "Política de Población Política de Cultura", en Plan Nacional Indicativo de Desarrollo 1979-1983.

Tableau 9: Changements dans les perceptions des gouvernements concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux, juillet 1978 - juillet 1980

Pays situés dans la Région de la CEPAL

	Perceptions des gouvernements concernant l'impact de l'accroissement naturel considéré comme une entrave au développement et désir d'intervention							
	Taux trop bas			Taux ni trop élevés ni trop bas		Taux trop élevés		
	Impact des entraves:					Impact des entraves:		
	(A) prédominant	(B) significatif	(C) Léger	pas d'entraves	(C) léger	(B) significatif	(A) prédominant	Total
	Taux plus élevés souhaitables			Taux plus élevés ou plus bas non souhaitables			Taux plus bas souhaitables	
	intervention globale appropriée	soutien partiel approprié		aucune intervention souhaitable		soutien partiel approprié	intervention globale appropriée	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Nombre de pays dans chaque catégorie en 1978	3	1	-	3	7	5	8	27
Changements dans les perceptions concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux durant la période 1978-1980	b		b	-Cuba	-Chile -Ecuador	-Costa Rica	b	
	b	+Chile	+Ecuador		+Cuba	+Dominica +St.Lucia +St.Vincent and the Grenadines	+Costa Rica	
Nombre de pays dans chaque catégorie en 1980	3	2	1	2	6	7	9	30

a) Les pays soulignés sont devenus Etats-Membres des Nations Unies ou de ses agences spécialisées durant la période 1978-80

b) Pas de changement
(+) Pays entrant dans cette catégorie
(-) Pays changeant de catégorie

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

comparable à celui des pays voisins. Il considère par conséquent que l'immigration devrait apporter le complément nécessaire qui lui permettra d'atteindre l'objectif fixé et en même temps des restrictions sévères sont apportées à l'émigration. Une large série de mesures sont mises en place en vue de réduire les différences régionales et sectorielles : créations d'emploi dans les zones rurales, meilleure distribution des revenus etc.

En Bolivie, dans le plan de développement actuellement en vigueur (1976-1980), le gouvernement met l'accent sur une augmentation de la population associée à une réorganisation des structures économiques et sociales en vue de maximiser l'économie d'un pays vaste, riche en ressources naturelles, et dont la population est mal distribuée. Parmi ces mesures socio-économiques, le gouvernement développe l'irrigation du pays, la commercialisation des produits nationaux, etc. en vue de permettre une meilleure distribution spatiale de la population et une amélioration de la productivité nationale capable de faire vivre une plus large population.

Enfin, 9 pays de la région se déclarent satisfaits de leur taux d'accroissement en 1980, ce qui représente à peu de choses près la situation qui prévalait en 1978. Cependant, la plupart de ces pays restent vigilants et maintiennent leur politique de soutien partiel. Ainsi en Equateur, le nouveau plan quinquennal de développement (1980-1984) met l'accent sur des changements socio-économiques importants et le développement rural (incluant la redistribution de terres expropriées à 77.000 familles, construction d'écoles, de logements sociaux, doublement du salaire minimum).

A Cuba 17/ le taux de natalité ne dépasse pas 15 p. 1000, ce qui représente une baisse de 39 p. 100 en 5 ans (de 1973 à 1978). Le taux de fécondité générale (70 p. 1000 femmes âgées de 15 à 44 ans) est actuellement un des plus bas d'Amérique latine et le plus récent déclin est survenu alors que la mortalité est quasi stabilisée au taux très bas de 5,6-5,8 p. 1000, de sorte que le taux d'accroissement a lui aussi diminué. La situation à Cuba paraît unique en ce sens que cette chute de la fécondité et de l'accroissement naturel ne résulte pas de mesures antinatalistes, ou en fonction d'objectifs démographiques pré-établis, comme dans un certain nombre de pays en développement. Elle semble résulter de la conjonction d'un ensemble de facteurs politico-économiques : amélioration des niveaux d'éducation, rendue obligatoire pour les enfants, par programmes spéciaux pour adultes, urbanisation des zones rurales par établissement de services sociaux et projets de développement, construction de petites communautés urbaines, réduction des disparités entre les revenus à la ville et à la campagne; efforts gouvernementaux pour améliorer le statut de la femme et augmenter sa participation dans l'économie par des programmes d'éducation, la mobilisation politique et le travail volontaire, la législation du code de la famille, le libre accès aux moyens de régulation de la fécondité, et plus récemment l'entrée des femmes dans la population active. A ces mesures s'ajoutent la mise en oeuvre d'un vaste programme gouvernemental dans le domaine de la santé incluant une campagne nationale d'éducation sur les soins maternels et infantiles, l'aspect santé découlant de la

17/ *Recent Trends in Fertility, Abortion and Contraception in Cuba*, Paula E. Hollerbach, The Population Council, Working paper No 61, September 1980.

régulation des naissances, une mise à disposition plus large des moyens de contraception et de l'avortement. En 1977 le rapport d'avortement légal 18/ qui mesure la proportion des grossesses terminées par un avortement légal atteignait 420 par mille grossesses, ce qui représente le taux le plus élevé enregistré au monde durant les années 1970.

Mais il semble que la situation pourrait changer dans un avenir proche: le taux de natalité est apparemment stabilisé mais pourrait augmenter avec l'arrivée à l'âge fertile des larges cohortes de femmes nées durant la période de forte natalité qui est survenue après la Révolution et qui a culminé dans les années 1963-1964.

Seuls parmi les pays satisfaits de leur taux, le Brésil et la Guyane n'ont mis en oeuvre aucune politique d'intervention faisant confiance à l'évolution spontanée du taux.

Peu de pays (cf. tableau 7) ont défini des objectifs quantitatifs à l'appui de leur politique: ce sont les 4 pays ayant adopté une politique d'intervention globale en vue de diminuer le taux d'accroissement naturel et 1 pays (l'Argentine) en vue de l'augmenter. Trinité-et-Tobago voudrait que le taux de natalité atteigne 15,5 p.1000 dès cette année. El Salvador considère possible d'atteindre un taux de croissance de 2,9 p.100 en 1982, soit un taux de natalité de 40,2 p.1000. Le Mexique s'est fixé d'atteindre un taux de croissance de 2,5 p.100 en 1982 et 1 p.100 après 2000. L'Argentine exprime son objectif de façon différente: elle voudrait pour l'an 2000 avoir une population de l'ordre de 40 à 50 millions d'habitants.

CEAO

Aucun pays n'a changé ni de perceptions ni de politiques depuis 1978 (cf. tableau 1 et 10). Un taux d'accroissement plus élevé est souhaité par 5 pays tandis que 7 autres s'en déclarent satisfaits. L'Asie occidentale reste la seule région des pays en développement où aucun pays ne désire voir diminuer le taux. Parmi les pays qui désirent augmenter leur taux, bien que 4 d'entre eux aient une politique d'intervention globale, aucun n'envisage de le faire par des mesures dans le domaine de la fécondité; les seules actions dans ce domaine sont prises par des pays qui sont satisfaits du taux d'accroissement et qui en général veulent maintenir à son niveau actuel la fécondité, à l'exception de l'Iraq qui voudrait la voir remonter et Bahrein et la Jordanie la voir diminuer. Par contre la quasi-totalité des pays de la région ont pris des mesures en vue d'agir sur la distribution spatiale, la migration internationale et sur les conditions socio-économiques. (Bahrain n'a aucune politique dans ces domaines et la Jordanie n'en a pas en migration internationale). La plupart des pays de la région continuent donc à compter sur l'immigration à défaut d'un accroissement naturel jugé non satisfaisant. Cependant, certains de ces pays (Oman, l'Arabie Saoudite, les Emirats Arabes Unis, Qatar, par exemple) se refusent à fonder à long terme leur politique d'accroissement de population sur l'immigration. Cependant, dans l'immédiat, et afin d'atteindre les objectifs de déve-oppement économique qu'ils se sont fixés, ces pays doivent continuer à faire appel à des contingents importants de main-d'oeuvre étrangère. D'autre part, aucun pays de la région n'a défini d'objectif quantitatif pour concrétiser ses politiques.

18/ Nombre d'avortements légaux pour 1000 grossesses (avortement plus naissances vivantes survenues durant la période de 12 mois qui commence six mois après l'année durant laquelle les avortements ont été enregistrés).

Tableau 10: Changements dans les perceptions des gouvernements concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux, juillet 1978 - juillet 1980

Pays situés dans la Région de la CEAO

	Perceptions des gouvernements concernant l'impact de l'accroissement naturel considéré comme une entrave au développement et désir d'intervention							
	Taux trop bas			Taux ni trop élevés ni trop bas		Taux trop élevés		
	Impact des entraves:					Impact des entraves:		
	(A) prédominant	(B) significatif	(C) léger	pas d'entraves	(C) léger	(B) significatif	(A) prédominant	Total
	Taux plus élevés souhaitables			Taux plus élevés ou plus bas non souhaitables			Taux plus bas souhaitables	
	intervention globale appropriée	soutien partiel approprié		aucune intervention souhaitable		soutien partiel approprié	intervention globale appropriée	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Nombre de pays dans chaque catégorie en 1978	4	1	1	1	5	-	-	12
Changements dans les perceptions concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux durant la période 1978-1980		b						
		b						
Nombre de pays dans chaque catégorie en 1980	4	1	1	1	5	-	-	12

b) Pas de changement

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

CESAP

La majorité des pays (19 sur 30) 19/ souhaite comme en 1978 un taux d'accroissement de la population plus bas (cf tableaux 1 et 11). Parmi eux, se trouvent les plus grands pays du monde : la Chine (956,8 millions d'habitants), l'Inde (693,8 millions), l'Indonésie (151,8 millions). Tous ont des politiques d'intervention globale 20/ et font porter leurs efforts entre autres sur la baisse de la fécondité. La Chine 21/ est le pays de la région, qui a dans la période récente, le plus attiré l'attention par les déclarations de ses dirigeants sur la nécessité de freiner la croissance de la population de façon encore plus radicale que ce qui avait été fait dans le passé. La constitution a été modifiée pour introduire une référence précise au fait que l'état encourageait la limitation des naissances et comme cela a été le cas pour d'autres campagnes politiques, un effort de mobilisation de masses a été immédiatement entrepris.

En Indonésie, où le taux d'accroissement reste encore élevé (2,3 p. 100), le gouvernement continue à déployer tous ses efforts pour diminuer la fécondité et résoudre le problème que pose l'accroissement de la population sur certaines parties du territoire 22/. C'est ainsi qu'il a décidé de transférer un demi-million de familles de l'île surpeuplée de Java dans d'autres îles du territoire d'ici 1984. Ce programme, extrêmement coûteux, s'inscrit dans le cadre de son plan quinquennal de développement 1979-1984 et vise, en plus de l'objectif immédiat déjà cité, d'accélérer le développement agricole des autres îles pour assurer l'auto suffisance du pays (cultures alimentaires déficitaires, nécessité d'accroître les cultures industrielles d'exportation, telles que le caoutchouc, l'huile de palme...).

En Inde, les changements successifs de gouvernements ont sérieusement affecté les programmes de réduction de la croissance de la population, particulièrement au niveau des programmes de la planification de la famille 23/. Le rythme du déclin des taux de natalité s'est considérablement ralenti durant les récentes années, en relation directe avec la proportion décroissante de couples pratiquant la contraception. Les autorités gouvernementales responsables s'efforcent de relancer la politique globale de réduction de l'accroissement naturel en redéfinissant de nouveaux objectifs comme nous le verrons plus loin (cf tableau 7). On compte dans la région cinq pays satisfaits de leur taux d'accroissement. Parmi ces pays, deux n'ont pas de politique (Les Maldives et la Birmanie) et trois en ont une (Afghanistan, Malaisie et Singapour) 24/. A Singapour, la rapide industrialisation associée à une forte baisse de la fécondité risque de poser à plus ou moins long terme un problème de main-d'oeuvre,d'autant plus que l'immigration est strictement contrôlée.

19/ Le Japon, l'Australie et la Nouvelle-Zélande sont exclus de la région.

20/ Les gouvernements des Iles Salomon, de Kiribati et de Tuvalu, pays ayant accédé récemment à l'indépendance n'ont pas encore exprimé officiellement leur position ni leurs politiques.

21/ E. Brennan et J.C. Chasteland, "Les politiques de population dans les pays d'Europe et du Tiers Monde, op.cit.

22/ People, Volume 7, No 2, 1980.

23/ People, Volume 7, No 3, 1980.

24/ En Afghanistan, situation en 1978.

Tableau 11: Changements dans les perceptions des gouvernements concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux, Juillet 1978 - Juillet 1980

Pays situés dans la Région de la CESAP

	Perceptions des gouvernements concernant l'impact de l'accroissement naturel considéré comme une entrave au développement et désir d'intervention							
	Taux trop bas			Taux ni trop élevés ni trop bas		Taux trop élevés		
	Impact des entraves: (A) prédominant	(B) significatif	(C) léger	Impact de l'entrave:	(C) léger	Impact des entraves: (B) significatif	(A) prédominant	Total
	Taux plus élevés souhaitables			Taux plus élevés ou plus bas non souhaitables		Taux plus bas souhaitables		
	intervention globale appropriée	soutien partiel approprié		aucune intervention souhaitable		soutien partiel approprié	intervention globale appropriée	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Nombre de pays dans chaque catégorie en 1978	5	1	1	2	5	-	16	30
Changements dans les perceptions concernant l'acceptabilité de l'accroissement naturel et désir de modifier les taux durant la période 1978-1980	b	b		-Singapore	-Burma		b	
	b	b	+Singapore	+Burma	b	+Solomon Islands +Kiribati +Tuvalu	b	
Nombre de pays dans chaque catégorie en 1980	5	1	2	2	4	3	16	33

a) Les pays soulignés sont devenus Etats-Membres des Nations Unies ou de ses agences spécialisées durant la période 1978-80

b) Pas de changement
(+) Pays entrant dans cette catégorie
(-) Pays changeant de catégorie

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

Six pays seulement considèrent leur taux d'accroissement trop bas. La plupart de ces pays (Mongolie, Kampuchea Démocratique 25/, République Démocratique Populaire Lao, République Populaire Démocratique de Corée 26/, sont des pays à économie planifiée et ont tous des politiques d'intervention globale. La République Démocratique Populaire de Lao et la Mongolie mettent particulièrement l'accent dans leurs interventions sur une augmentation ou un maintien de la fécondité. Dans ce dernier pays, un programme complet de mesures d'encouragement et de dissuasion a été mis en oeuvre lors de l'exécution du 5ème Plan de développement de 1971-75 et renforcé encore dans le 6ème Plan de 1976-80. 27/

Nombreux sont les pays asiatiques qui ont défini des objectifs quantitatifs à l'appui de leur politique (cf. tableau 7). La Chine fixe un taux d'accroissemen de 5 p. 1000 à atteindre en 1985 et de 0 p. 1000 en 2000; les familles devraient se limiter à un enfant. La République de Corée voudrait voir son taux de croissance atteindre 1,6 p. 100 en 1981; l'Indonésie 2 p. 100 durant la période 1979-84 et un taux de natalité de 34 p. 1000 en 1984; la Malaisie, 2 p. 100 en 1985 et un taux de natalité de 28,2 p. 1000 dès 1980; Singapour se fixe comme objectif un taux de croissance de zéro en 2000; le Vietnam, 2 p. 100 en 1980, 1,5 p. 100 en 1985 et 1 p. 100 en 2000; la Thaïlande, 2,1 p.100 en 1981; l'Inde un taux net de reproduction de 1 en 2000 partout dans le pays.

Plusieurs pays revisent périodiquement leurs objectifs en fonction de l'évolution de la situation et en même temps qu'ils définissent ces objectifs, ils établissent une stratégie détaillée en vue de les réaliser.

Les Philippines dans leur réponse à la quatrième enquête démographique auprès des gouvernements en 1978, avaient fixé comme objectif un taux de croissance de 2,3 p. 100 à atteindre en 1982 et de 2,1 p. 100 en 1987. Lors de son onzième séminaire 28/, tenu à Manille en juin-juillet 1980, la Commission de la population a fixé comme l'objectif immédiat du programme de population la réduction du taux annuel d'accroissement de 2,3 p. 100 (1980) à 2,0 p.100 en 1985; cet objectif devrait permettre d'atteindre un taux net de reproduction de 1 par an en l'an 2000, la population des Philippines serait alors de 67 millions selon les projections actuelles.

Non seulement un objectif global a été fixé, mais la stratégie pour atteindre cet objectif a été clairement présenté: augmenter le taux d'accroissement des services de planification familiale d'un niveau prévu de 45 p. 100 en 1981 à 53 p. 100 en 1985; encourager le mariage à un âge plus avancé et diminuer la proportion des femmes mariées de moins de 20 ans de 50 p. 100 en 1978 à 42 p. 100 en 1985; promouvoir la norme de la famille de taille réduite et influencer les familles pour que le nombre désiré d'enfants tombe de 4,4 en 1978 à 3,0 en 1985; surveiller et analyser les autres facteurs du développement, tels que le revenu, l'emploi, la santé et l'éducation et voir comment ils affectent le processus de prise de décision dans le domaine de la population.

25/ Situation en 1977.

26/ Situation en 1976.

27/ Mongolia. Population Policy Compendium:situation as assessed in June 1979, a joint publication of the Population Division of the United Nations Department of International Economic and Social Affairs and the United Nations Fund for Population Activities.

28/ Population Headliners, No. 66 September 1980; Population Division Economic and Social Commission for Asia and the Pacific, United Nations, Bangkok, Thailand.

Un autre exemple de révision d'objectif est celui de l'Inde. L'objectif déclaré lors de la quatrième enquête était caractérisé par un taux de natalité de 30 p. 1000 à atteindre en 1983 et de 27 p. 1000 en 1986-1991. Mais à la suite du relâchement des politiques gouvernementales, le pourcentage des couples utilisant des moyens contraceptifs a décliné durant ces dernières années. En 1977, 24 p.100 des couples âgés de 15 à 44 ans utilisaient l'un ou l'autre moyen de contraception, en 1978, le pourcentage était de 22,8 p. 100 et en juin 1979 de 21,6 p. 100. Le groupe de travail sur les politiques de population a soumis l'an dernier son rapport à la Commission de la Planification dans lequel il propose maintenant comme objectif un taux net de reproduction de 1 en l'an 2000 pour l'ensemble du pays, et plus tôt pour certaines régions. 29/ Pour atteindre cet objectif, la taille moyenne de la famille, 6 enfants nés vivants, 4,2 enfants survivants, devrait passer dans l'ensemble du pays à 2 enfants. Le taux de natalité devrait diminuer de la sorte de son niveau actuel de 33 p. 1000 à 21 p. 1000 en 1996.

Dans les pays en développement, l'étendue et l'intensité des interventions gouvernementales varient considérablement d'une région ou d'un pays à l'autre, traduisant par là la variété même des situations démographiques. Les pays en développement qui sont encore au début de la transition démographique et qui considèrent leur taux d'accroissement comme trop bas donnent en général une priorité à la réduction de la mortalité et aux problèmes de distribution spatiale de la population, la fécondité et les migrations internationales recevant une priorité moindre. Parmi les pays dont la fécondité et la mortalité sont basses, ce sont les interventions sur la fécondité qui prédominent.

Les pays en développement qui perçoivent leur taux d'accroissement trop élevé,interviennent généralement de façon à réduire la fécondité et à maîtriser les mouvements de déplacement interne de la population,et à réorganiser la configuration rurale et urbaine du pays. Les efforts de restructuration économique reçoivent une priorité élevée.

Quant aux pays en développement qui considèrent le taux d'accroissement comme étant satisfaisant, les interventions gouvernementales tendent à s'aligner sur celles des pays développés: les actions dans le domaine de la fécondité visent plus au bien-être individuel qu'à un objectif démographique. Les interventions sur les autres variables démographiques jouent encore un rôle important mais non essentiel, tandis que les changements de structure socio-économiques comme dans l'ensemble des pays en développement, restent toujours prioritaires.

Conclusion

De l'ensemble des remarques présentées dans le présent chapitre, il résulte que des différences considérables existent d'une région à l'autre, ou même d'un pays à l'autre, à l'intérieur d'une même région au niveau des perceptions du taux d'accroissement naturel de la population, quant aux options d'intervention et de l'intensité des politiques mises en oeuvre.

29/ People, Volume 7 Number 3, 1980

Dans les pays développés où cependant la situation démographique est plus homogène, les réponses gouvernementales n'en varient pas moins, tant au niveau des perceptions qu'à celui des moyens d'action à mettre en oeuvre. Ces réponses en fait sont surtout basées sur des appréciations divergentes sur les conséquences sociales et économiques des tendances démographiques. Dans les pays en développement, la situation démographique et économique est beaucoup plus variée que dans les pays développés. Les réponses gouvernementales reposent plus sur des considérations économiques; les pays les plus engagés dans la transition démographique sont aussi ceux qui en général se montrent les plus concernés par les problèmes démographiques. Ces réponses diffèrent, mais on constate quand même une homogénéité d'attitudes des pays dans les régions de la CESAP ou de la CEAO.

Dans leur grande majorité les pays décident d'intervenir avec plus ou moins d'intensité en vue de modifier ou de controler le taux d'accroissement de la population. Seuls 17 pays sur 165 n'ont pris aucune mesure, faisant confiance aux mécanismes d'évolution spontanée du taux, ou bien estimant inopportun d'agir dans le contexte politique et social du pays. La majorité des pays non satisfaits de leur taux ont des politiques globales d'intervention (25 pays sur les 35 estimant le taux trop bas, 38 pays sur les 55 estimant le taux trop élevé)

Cependant les gouvernements n'ont pas toujours entière liberté d'action. A leur volonté d'intervention ou aux stratégies qu'ils élaborent peuvent s'opposer des circonstances qui freinent, ou même remettent en question ces interventions. Ainsi dans les pays développés, en dehors des tendances sociales à long terme qui introduisent des contraintes dans le champ d'intervention gouvernemental, des évènements conjoncturels peuvent jouer un rôle non négligeable sur l'évolution démographique à court terme des pays industriels. C'est ainsi que l'inflation, la récession et la baisse du niveau de l'emploi peuvent avoir contribué à modifier les intentions des couples concernant la taille finale de leur descendance. Il faut aussi prendre en compte le freignage ou la réduction dans certains pays des dépenses gouvernementales consacrées aux familles. Par ailleurs, l'augmentation du chômage contribue à réduire très fortement la demande de la main-d'oeuvre étrangère, avec comme conséquence, la fermeture des frontières aux nouveaux immigrants, et elle peut provoquer en outre des déplacements de population dans les régions affectées par la crise de l'emploi.

Dans les pays en développement, en plus de contraintes structurelles (économiques, financières, administratives, technologiques, culturelles, etc.) qui limitent les possibilités réelles d'intervention des gouvernements, les évènements conjoncturels ont eu des répercussions spécifiques sur leur capacité d'intervention. La récession et l'inflation ont atteint particulièrement des pays dont les économies dépendaient étroitement d'importations de produits alimentaires, manufacturés ou pétroliers. Cette crise, en réduisant les ressources dont disposaient les gouvernements a amené nombre d'entre eux à limiter leur action dans le domaine des dépenses de services publics (par exemple l'éducation, la santé, etc). Par contre la crise a conduit des gouvernements à mettre davantage l'accent sur un développement autocentré, et notamment sur le développement du secteur rural, etc.

Chapter 18

MORTALITY, MORBIDITY AND HEALTH POLICIES

Introduction

While all countries have policies to improve the health and well-being of their citizens, many governments are not satisfied with the achievements of their policies. The recent United Nations Fourth Population Inquiry Among Government and the subsequent 1979 Monitoring Report have found that 197 of the 165 countries view their present levels of average life expectancy as unacceptable in the prevailing economic and social circumstances (See Table 1).

Population policies are fundamentally related to those of health, morbidity and mortality. Policies to reduce morbidity are directly linked with lowering mortality, they will affect the natural rate of population increase and are also likely to affect fertility in different ways. The complex interrelationships between fertility and infant and child mortality are matched by the complex relationships among population policies and health policies. There are overlapping targets for high risk groups - children and women in the reproductive ages-and thus the joint emphasis on family health, maternal and child health care, including family planning is particularly linked with the emerging emphasis on primary health care. The decentralization of medical services and the extension of health coverage to the rural areas may compliment policies affecting spatial distribution. The greater attention to the non-medical determinants of health and the emphasis being given to widening the population's access to these elements is also of increasing interest to those countries formulating various population policies. Governments have emphasized their concern about mortality in the United Nations Fourth Population Inquiry Among Governments.

The World Population Plan of Action established the goal for the achievement of an expectation of life at birth of 62 years of age as a world average by 1985 and of 74 years of age by the end of this century. On average the developed countries are expected to reach these targets, however estimates and projections developed by the Population Division indicate that Africa and much of Asia, and thus the developing countries on average are no longer likely to reach this level. In fact, the developing countries may only achieve an expectation of life at birth of 63 to 64 years of age by the year 2000. This would be a modest gain, only slightly above the target set for 1985.

Of the thirty nine more developed countries, nine considered their average levels of life expectancy as unacceptable in their prevailing economic and social circumstances (See Table 1). Among many developed countries, there is continued concern over the substantial differentials in mortality of various groups and social classes. Also of particular interest is the excess mortality among adult males and the gap, which, in

Table 1. Average life expectancy at birth, 1975-1979, and Governments' perceptions of its acceptability in prevailing economic and social circumstances, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980 a/

Areas of responsibility of Regional Commissions, demographic statistical regions and general level of development		Levels of expectation of life at birth										
		70 years and over		62 b/ - 69 years		50 - 61 years		50 years and under		All ages		Total
		A b/	Un c/	A b/	Un c/	A b/	Un c/	A b/	Un c/	A b/	Un c/	
ECA Area:	Eastern Africa	-	-	1	1	-	3	1	9	2	13	15
	Middle Africa	-	-	-	-	-	-	-	9	-	9	9
	Northern Africa	-	-	-	-	-	5	-	1	-	6	6
	Southern Africa	-	-	-	-	-	3	-	2	-	5	5
	Western Africa	-	-	-	-	-	1	-	15	-	16	16
	Total	-	-	1	1	-	12	1	36	2	49	51
ECE Area:	Eastern Europe **	5	-	1	-	-	-	-	-	6	-	6
	Northern Europe **	5	2	-	-	-	-	-	-	5	2	7
	Southern Europe **	5	1	1	2	-	-	-	-	6	3	9
	Western Europe **	8	1	-	-	-	-	-	-	8	1	9
	Cyprus, Israel, Turkey	2	-	-	-	-	1	-	-	2	1	3
	Northern America **	2	-	-	-	-	-	-	-	2	-	2
	USSR **	-	3	-	-	-	-	-	-	-	3	3
	Total	27	7	2	2	-	1	-	-	29	10	39
ECLA Area:	Caribbean	3	-	1	5	1	1	-	-	5	6	11
	Middle America	-	-	2	2	-	3	-	-	2	5	7
	Temperate South America	-	-	2	1	-	-	-	-	2	1	3
	Tropical South America	-	-	1	5	1	2	-	-	2	7	9
	Total	3	-	6	13	2	6	-	-	11	19	30
ECWA Area:	Western South Asia (part)	-	-	2	2	4	-	-	4	6	6	12
ESCAP Area:	China	-	-	-	1	-	-	-	-	-	1	1
	Japan **	1	-	-	-	-	-	-	-	1	-	1
	Other East Asia	-	-	1	2	-	-	-	-	1	2	3
	Eastern South Asia	-	-	1	-	2	3	-	3	3	6	9
	Middle South Asia	-	-	1	-	-	3	-	5	1	8	9
	Australia-New Zealand **	2	-	-	-	-	-	-	-	2	-	2
	Melanesia	-	-	-	-	-	1	-	1	-	2	2
	Micronesia-Polynesia	2	-	-	4	-	-	-	-	2	4	6
	Total	5	-	3	7	2	7	-	9	10	23	33
More developed **		28	7	2	2	-	-	-	-	30	9	39
Less developed		7	-	12	23	8	26	1	49	28	98	126
	Total	35	7	14	25	8	26	1	49	58	107	165

a/ Names of countries are listed in Table A.XVIII.1.
b/ Acceptable
c/ Unacceptable

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

some countries is widening, between male and female mortality at older ages. A number of new policies are being formulated in response to these concerns which include measures specially targeted to high risk groups as well as various preventive health programmes. Some of the same types of measures are being integrated into the quite diverse health and social services found among the planned economy and mixed economy countries of the developed world.

Among the 126 developing countries, only 28 consider their level of life expectancy to be acceptable while 98 consider it unacceptable even under their prevailing economic and social circumstances (See Table 1). By far, the greatest number of governments which view their own mortality levels as unacceptable are found in the ECA region (49 out of 51 countries); followed by the ESCAP region, the ECLA region and the ECWA region.

In the ECA region where life expectancies are lowest, the governments themselves often consider poor health and high mortality their most serious population problems. Only two countries consider their mortality levels acceptable. The mortality conditions in Sub-Saharan Africa are the world's most severe, and few gains have been made in recent years leaving the expectation of life well below 50 years. Substantial improvements have been made in a few island countries. In North Africa, estimates of life expectancies often range between 55 and 60 years, with certain notable exceptions.

Recently, there have been widespread changes in the formulation of health policies in ECA countries in support of the principles of primary health care, which if implemented would likely have a significant demographic impact. Because of these changes in health and mortality policies and because of their potential impact in the ECA region, special attention have been placed upon the diversity of African health policy objectives in this chapter.

In the ECWA region, where many of the countries have experienced rapid economic growth, there has not been a parallel implementation of primary health care nor has there been an accelerated decline in mortality. Of the twelve countries in the ECWA region, half consider their average level of live expectancy at birth to be unacceptable under prevailing economic and social circumstances. A number of countries in the region are however formulating health and population policies which are specifically designed and targeted to rural and underprivileged populations.

Countries in the ECLA region have achieved substantially higher levels of life expectancy than the other regions in the developing world. And yet, further progress in reducing mortality has apparently slowed in a number of countries and this is causing some concern. Of the thirty

ECLA countries, nineteen consider their level of life expectancy to be unacceptable under prevailing economic and social circumstances.

The high levels of mortality remain a major concern to many countries of South Asia is within the range of 50 to 60 years, although South Asia, still have life expectancies of less than 50 years, although most of the South Asia is within the range of 50 to 60 years. Twenty three of the thirty three ESCAP countries consider their average level of life expectancy at birth to be unacceptable under prevailing conditions. Health policies receive considerable attention and are often an integral part of the overall development plans. The health policies of China have been particularly impressive and the country has experienced a very substantial increase in its average life expectancy.

The formulation and implementation of health policies in many countries is undergoing major changes. There is a great deal of dissatisfaction over many of the earlier approaches to health care and a broad consensus is emerging in many countries which supports the principles of primary health care. 1/ To the extent that these programmes are implemented, they are likely to have profound demographic consequences; even when they are not explicitly motivated for demographic purposes. Many of the measures, and particularly the emphasis on maternal and child health care complement population and family planning programmes. The increased attention to infant and child mortality has implications for future population growth as well as for the complex relationships between infant mortality and fertility. The non-medical determinants of health, the environmental aspects of health, and the relationships between the structure of development and health are also receiving greater attention and have important demographic significance.

This change in emphasis has been reflected in the recent planning of many governments and in the activities of WHO and UNICEF, which jointly sponsored the Alma-Ata Conference on Primary Health Care in 1978. 2/ The 1979 International Year of the Child and the United Nations 1980s Decade for Drinking Water and Sanitation Conference have also focused widespread attention to these problems, as well as the activities of a number of other international agencies.

1/ WHO, Sixth Report on the World Health Situation 1973-1974, Parts I and II, Geneva, 1980; WHO, UNICEF, International Conference on Primary Health Care, Statements by Participants in the Plenary Meetings, (Alma-Ata, 1978), ICPHC/ALA/78.11.

2/ See the "Declaration of Alma Ata", from the WHO/UNICEF International Conference on Primary Health Care. WHO, Primary Health Care: Report on the International Conference on Primary Health Care, Alma-Ata, U.S.S.R. 6-12 September 1978, (Geneva: WHO, 1978).

Implementation of such ambitious objectives remains a formidable challenge. There are numerous financial, administrative, and political constraints to these policies and they are often closely tied to the structure of development. The last section of this chapter examines some of the emerging problems, issues, and policy trends.

A. MORE DEVELOPED REGIONS

(Countries of ECE Region, excluding Cyprus, Israël and Turkey, but in addition including Australia, Japan and New Zealand).

In the more developed regions even among countries with long life expectancies, progress has often been less than satisfactory in reducing differential mortality and mortality among adult males, although some new progress has recently been noted. 3/ In this respect many new measures and approaches are being undertaken in a number of countries although few have been implemented with specific demographic rationals. 4/

A majority of countries in the ECE region (29) consider their level of mortality--as measured by the average expectation of life at birth--to be acceptable, although 10 countries, including 7 which have an average life expectancy of more than seventy years, consider it to be unacceptable. Countries in the ECE region with the highest life expectancies, share a number of similar concerns: reducing the incidence of cardiovascular diseases and vehicular accidents, waging campaigns against the effects of excessive alcohol consumption and smoking. In all regions of the ECE, as well as in Northern America and the USSR, health education campaigns have been given a high priority. There is a greater realization that individual choices affect health life styles and are clearly affected by social pressure and commercial advertising as well as by health education and information measures. Thus, policies affecting environmental health and

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3/ Jean Bourgeois-Pichat, "Long-Term Population Projections and their Social and Economic Consequences", United Nations Training Workshop in Population Projections, Budapest, 17-28 March 1980. Mimeo.

4/ WHO, Report of the Regional Director for the European Region, WHO, International Conference on Primary Health Care, Alma Ata, U.S.S.R., September 1978, ICPHC/ALA/78.7; I.P. Lidov, A.M. Stochik, G.F. Tserkovny, Soviet Public Health and the Organization of Primary Health Care for the Population of the USSR, Mir Publishers, Moscos, 1978; T. Sh. Sharmanov, Experience of Organization of Primary Health Care in Kazakh SSR, Ministry of Health, Alma-Ata, 1978; Ministry of Health and Social Welfare, Health Care in the Polish People's Republic, Report on the International Conference on Primary Health Care, Alma-Ata, 1978; The Czechoslovak Government, the Czechoslovak Health Service, 1978; People's Republic of Bulgaria, Primary Health Care in the Bulgarian National Public Health System, Sofia, 1978; The Swedish National Board of Health and Welfare, Primary Health Care. A Swedish Project, Stockholm 1977

preventive measures aimed at influencing behavioural factors are receiving greater attention. Health education and preventive programmes which emphasize the relationships between tobacco smoking, excessive drinking, overnutrition, insufficient excercise and stress with cancer, coronary heart disease, alcoholism and obesity, are being widely adopted in the region.

In this connection, a number of countries are also concerned with reducing differentials between adult male and female mortality. For example, France reported that while the level of female mortality is acceptable, that of France's males is unacceptable. The United Kingdom reported that it has focused increasing attention on preventive health measures since 1976, when it published a white paper on prevention and health; and Finland has initiated special projects aimed at reducing the mortality of males over the age of 45.

Contamination of air, water and food, hazards in the workplace, unsafe highway and automobile design, dangerous consumer products and radiation exposure are some of the other major risks in the physical environment that are of concern in the region. Income, housing, employment, family ties and social supports are also recognized as factors affecting the mortality risks in the socio-economic environment.

Although a majority of the countries in the ECE region have low infant and child mortality, a number of countries place an emphasis on reducing it still further: Denmark has enacted legislation requiring the examination of all expectant mothers and children; the Federal Republic of Germany approved legislation in 1974 requiring pre-natal examinations and periodic examinations of children. Finland has achieved infant mortality rate of 10 deaths per 1,000 live births in 1976 with no significant urban-rural or regional differentials. It has a very effective immunization programme with 98 per cent of the children receiving PDT and BCG vaccinations. Expectant mothers averaged 13.3 visits to a nurse and 3.3 visits to a doctor during their pregnancy. Despite many achievements in reducing infant mortality several of the wealthiest developed countries continue to experience substantial regional,class and ethnic differentials in their infant mortality rates.

Access to services which promote, maintain or restore health is associated with differential mortality. In the ECE region, countries have a number of different health care systems ranging from those where the State provides free and easily accessible health care to the whole population as a social service. However, in the United States a sizeable number of people have no health insurance, while a large number have inadequate coverage. Nearly 50 million people live in rural or urban localities officially designated as underserved.

Many of the developed countries consider regional differentials to be an area of continuing concern. A variety of programmes are being implemented each reflecting the needs of the individual countries concerned: The Federal Republic of Germany aims to reduce regional differentials through the establishment of regional health service offices; Greece, through the expansion of rural medical centres and the utilisation of helicopters: the Netherlands, through hospital construction and subsidies to home care services in rural areas; Romania, through the creation of medical dispensaries in each community; Spain, through the extension of social security to the countryside; Sweden, through district doctors and nurses who visit patients in their homes.

Some of the principles of primary health care which have been fundamental policies in a number of countries, especially those of Eastern and Northern Europe, are now receiving greater attention and acceptance throughout the region. 5/ The curative medicine approach, with its high technology and required advanced medical training, has contributed to a rapid escalation of health costs. In many developed countries these costs have risen more rapidly than those of any other sector. In this connection there is a greater interest in the utilization of paramedical personnel, to reduce costs and improve efficiency and also, to further integrate health within preventive, primary, and social service efforts; and to foster an active rather than passive role in the identification of target populations.

There is generally a greater attention to underseved populations, community participations, and collaboration between consumers and providers. More efforts are being made to involve the consumer, both collectively and individually, in the planning and implementation of health care services. Problems relating the effectiveness and efficiency of primary health care, and the need for better evaluation, allocation of resources, new information systems, and measures to screen for disease and populations at risk are also being considered.

A change of focus is appearing in a growing number of countries with regard to the relationships between primary health care and the wider health care system; and among hospitals, health centres, polyclinics, and local teams. There is also greater interest in policies and measures affecting the integration of health with social care and even community development. Finland's health policy for example, has had a major re-orientation giving a high priority to primary health care which includes a high degree of community involvement and participation. 6/

5/ Leo A. Kaprio, Primary Health Care in Europe, EURO Reports and Studies No. 14, Regional Office for Europe WHO, Copenhagen, 1979.

6/ Ministry of Social Affairs and Health, National Board of Health, Primary Health Care in Finland, Helsinski, 1978.

The links between changes in health conditions and changes in governmental expenditure in health are exceedingly complex. Of course changes in the proportion of the G.D.P. spent on health services are much less likely to be reflected in changing health conditions than are changes in the level of living itself. Health and medical care are often financed by expenditures of individuals and or by private institutions. Among the developed countries with market economies, government expenditure on health services averaged 2 per cent of the Gross Domestic Product in the mid 1970s. However, 5 per cent or more was spent on health services by the Government of the Federal Republic of Germany, New Zealand, Norway and the United Kingdom. 7/

Among the developed countries, even among those with the highest life expectancies, progress in further reducing mortality has often been considered unsatisfactory. Differential mortality and adult male mortality remain particular concerns as do risks from both the physical and socio-economic environments. Preventive health policies are being implemented in much of the region. Access to medical services continues to be a policy issues in some of the mixed economy countries. Health costs have increased throughout the region more rapidly than in almost any other sector.

B. LESS DEVELOPED REGIONS

ECA

African countries have the lowest life expectancies and consider poor health and low life expectancy to be their most serious population problems. The Governments of Africa are more dissatisfied with their current levels of morbidity and mortality than in any other region. Only two countries consider their average level of life expectancy at birth to be acceptable under prevailing economic and social circumstances while 49 countries consider it to be unacceptable. Some 37 countries in the ECA region have life expectancies of less than 50 years, while another 12 countries have life expectancies in the range of 50-62 years--which is below the average level of life expectancy of 62 years recommended by the World Population Plan of Action.

Although many countries in the ECA region will not achieve the mortality reduction of the dimension recommended by the World Population Plan of Action, many governments report that they do aim to achieve substantial progress. A number of countries have identified quantitative mortality targets including: Botswana, Burundi, Egypt, Ethiopia, Kenya, Madagascar, Morocco, Niger, Nigerai, Senegal, Seychelles, Sierra Leone, Somalia and Togo. Egypt a country with relatively good demographic data,

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7/ United Nations, Department of International Economic and Social Affairs, Patterns of Government Expenditure on Social Services, Supplement to the 1978 Report on the World Social Situation, ST/ESA/87/Add.1, p.35.

identified precise targets: to reduce the crude death rate from 14.2 to 13 per thousand and the infant mortality rate from 119 to 80 per thousand live births by 1982. Kenya expressed its target in terms of increasing life expectancy at birth: from 49 to 60 years by the year 2000. A number of countries reported that they could not identify quantitative targets--or be at all specific concerning prevailing mortality trends because of major inadequacies in the available data.

Since the governments of the ECA region often consider poor health and high mortality their most serious population problem, a special content analysis of the policy health objective of 45 countries was undertaken by the Population Division and is presented in Tables 2 and 3. The objective of this study was to determine to what extent the principles being articulated in international forums were actually being incorporated into recent plans and programmes of developing African countries and to see how they were likely to interact with population policies regarding fertility, mortality, and migration.

The training of health workers was rated as a policy priority by all the countries studied and this reflected a great shortage in the region (see Table 2). The control of endemic diseases, sanitation efforts, immunization and maternal and child health were recognized as a policy priority by more than 90 per cent of the countries. Efforts to promote potable drinking water and the extension of health coverage, often to rural areas, was also an overwhelming priority. Nutrition, food and health education were recognized as priority health areas by about three quarters of the countries studied. The first category included food subsidies and agricultural policies as well as the nutritional education measures most often found in connection with maternal and child health care measures. Particular attention was given to the nutrition of children and pregnant and lactating women. Health education was another high priority area; sometimes it involved specifically targeted adult education programmes, but often it was emphasized as a part of the family health strategy which included immunization, MCH, nutrition, and family planning.

About two thirds of the countries expressed some interest in the concept of community involvement in health; in some cases this meant the community would employ health workers and assist in establishing the priority of measures to be undertaken within the village. The concept of the village or community health worker was articulated as a priority by more than half the countries, and it often represented a strategy of decentralization of medical services and in some cases a method of incorporating the traditional birth attendants and paramedical workers into a referral network. Twenty countries, 47 per cent, mentioned family planning services as a health policy objective. The emphasis in this region was usually for contraceptives in order to space births or for family health reasons and it was often integrated with MCH programmes.

Table 2

Analysis of Health Policy Objectives
for Forty-five African Countries *
(as assessed in July 1980)

	PRIORITY		NOT A PRIORITY		TOTAL	
	Number	Per cent	Number	Per cent	Number	Per cent
Health Education	32	74	11	26	43	100
Nutrition and Food	33	77	10	23	43	100
Drinking Water	38	88	5	12	43	100
Sanitation	40	93	3	7	43	100
Maternal and Child Health	39	91	4	9	43	100
Family Planning	20	47	23	53	43	100
Immunization	39	91	4	9	43	100
Control of Endemic Disease	42	98	1	2	43	100
Provision of Essential Drugs	19	44	24	56	43	100
Extension of Health Coverage (Especially in rural areas)	38	88	5	12	43	100
Community Involvement in Health	28	65	15	35	43	100
Village Health Workers	26	60	17	40	43	100
Training of Health Workers	43	100	0	0	43	100

* Source: United Nations Population Division Study of Health and Mortality Policy objectives in Africa.

Table 3

Analysis of Health Policy Objectives
for Forty-five African Countries *

Countries	Health Education	Nutrition and Food	Drinking Water	Sanitation	Maternal and Child Health	Family Planning	Immunization	Control of Endemic Diseases	Provision of Essential Drugs	Extension of Health Coverage (especially in rural areas)	Community Involvement in Health	Village Health Workers	Training of Health Workers
Angola	x	x	x	x	x		x	x		x		x	x
Benin	x	x	x	x	x		x	x		x			x
Botswana 1/	x	x	x	x	x	x	x	x	x	x	x	x	x
Burundi 2/			x	x			x	x	x				x
Cape Verde		x			x				x	x			x
Central African Rep. 3/	x		x	x	x		x	x					x
Chad 4/	x		x	x	x		x	x		x	x	x	x
Comoros 5/		x	x	x	x		x	x		x	x	x	x
Congo 6/	x	x	x		x	x	x	x	x	x	x		x
Equatorial Guinea		x	x	x	x			x		x		x	x
Ethiopia 7/	x	x	x	x	x		x	x	x	x	x		x
Gabon 8/		x	x	x			x	x		x	x		x
Gambia 9/	x	x	x	x	x	x		x		x	x	x	x
Ghana 10/			x	x	x		x	x		x	x	x	x
Guinea 11/			x	x	x		x	x	x	x	x	x	x
Guinea-Bissau 12/	x	x		x	x	x	x	x	x	x	x		x

Table 3 (continued)

Analysis of Health Policy Objectives
for Forty-Five African Countries *

Countries	Health Education	Nutrition and Food	Drinking Water	Sanitation	Maternal and Child Health	Family Planning	Immunization	Control of Endemic Diseases	Provision of Essential Drugs	Extension of Health Coverage (especially in rural areas)	Community Involvement in Health	Village Health Workers	Training of Health Workers
Ivory Coast 13/	x	x	x	x	x	x	x	x		x	x		x
Kenya 14/	x	x	x	x	x	x	x	x	x	x	x	x	x
Lesotho 15/		x	x	x	x	x	x	x	x	x		x	
Liberia 16/	x	x	x	x	x	x	x	x		x	x	x	x
Madagascar 17/	x	x		x	x		x	x		x			x
Malawi 18/	x	x	x	x	x		x	x		x	x	x	x
Mali 19/	x	x	x	x	x	x	x	x		x	x	x	x
Mauritania	x	x	x	x	x		x	x		x	x	x	x
Mauritius 20/	x	x		x	x	x	x	x		x	x	x	x
Mozambique	x	x	x	x	x	x	x	x	x	x	x	x	x
Namibia 21/													
Niger	x	x	x	x	x		x	x	x	x	x	x	x
Nigeria	x	x	x	x	x	x	x	x	x	x	x	x	x
Reunion 22/	x		x	x	x	x	x	x					x
Rwanda 23/		x	x	x	x		x	x	x		x		x
Sao Tome and Principe 24/		x	x	x	x		x	x		x		x	x

Table 3 (continued)

Analysis of Health Policy Objectives
for Forty-Five African Countries *

Countries	Health Education	Nutrition and Food	Drinking Water	Sanitation	Maternal and Child Health	Family Planning	Immunization	Control of Endemic Diseases	Provision of Essential Drugs	Extension of Health Coverage (expecially in rural areas)	Community Involvement in Health	Village Health Workers	Training of Health Workers
Senegal 25/		x	x	x	x	x	x	x		x	x	x	x
Seychelles	x			x	x		x				x		x
Sierra Leone 26/	x	x	x	x	x	x	x	x		x			x
Saint Helena 27/													
Swaziland 28/	x		x	x	x	x	x	x		x		x	x
Togo 29/	x		x	x			x	x		x			x
Uganda 30/	x	x	x	x	x	x	x	x	x	x	x	x	x
United Rep. of Cameroon	x	x	x	x	x		x	x	x	x	x		x
United Rep. of Tanzania	x	x	x	x	x		x	x	x	x	x	x	x
Upper Volta	x	x	x	x	x		x	x		x		x	x
Zaire	x	x	x	x	x	x	x	x	x	x	x	x	x
Zambia	x	x	x	x	x	x	x	x	x	x		x	x
Zimbabwe 31/	x		x	x			x	x	x	x	x		x

Source: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978, Population Division, Population Policy Data Bank and from: WHO, Regional Office for Africa, Proposed Programme Budget 1982-1983, Thirtieth Session of the Regional Committee, Brazzaville,1980, (WHO/AFR/RC 30/2); and WHO, Biennial Report of the Regional Director. The Work of WHO in the African Region, 1977-78.

Notes to Table 3

1/ Special emphasis on a new hospital in Francistown and on occupational health.

2/ Special emphasis on hospital development.

3/ Special emphasis on modernizing existing hospital facilities.

4/ Special emphasis on malaria control.

5/ Special attention to malaria control and oral rehydration services.

6/ Special attention to integration of curative with traditional services and into overall development efforts and to the development of hospitals, health surveillance, and malaria control.

7/ Special attention to malaria control programmes.

8/ Special attention to hospitals, research and training and to malaria control programmes.

9/ Special attention to malaria control programmes.

10/ Special attention to medical research, health surveillance and malaria control programmes.

11/ Special attention to the development of hospitals, laboratory services and research, and to malaria and parasitic control programmes.

12/ Special attention to the development of laboratory, services and health surveillance and professional health training.

13/ Special attention to malaria control programmes and health surveillance.

14/ Special attention to development of hospitals and health research and the integration of health services into other ministries.

15/ Special emphasis to upgrade curative facilities for national self-sufficiency.

16/ Special attention to the further development of health infrastructure and laboratory and x-ray services.

17/ Special emphasis on occupational health, hospitals, malaria and parasitic disease control.

18/ Special emphasis on diagnostic, therapeutic, and rehabilitation services.

19/ Special emphasis on the integration of health activities with otner ministries, especially agriculture, water, and education; and the development of health statistics.

20/ Special emphasis on district hospitals and malaria control.

21/ Under illegal occupation of South Africa. WHO provides health care support for Namibians in Zambia and Angola and through health assistance to SWAPO.

22/ Special emphasis on the control of malaria and parasitic diseases.

23/ Special emphasis on hospital development and the integration of health and social services.

24/ Special emphasis on malaria control, school health services and the development of laboratory services.

25/ Emphasis on health research and development.

26/ Emphasis on the development of laboratory services and health surveillance.

27/ Emphasis to maintain existing high standards. Universal access to medical coverage.

28/ Special emphasis upon rehydration facilities schistosomiasis and malaria control programmes.

29/ Special emphasis on the integration of PHC into rural development projects.

30/ Special emphasis on reconstruction of hospitals and all medical facilities damaged by war.

31/ The years of war have had adverse effects upon health. The country is now undergoing significant reorganization of health services including the rehabilitation of war victims.

More countries may be actually supporting family planning but only twenty indicated they were doing so as part of their priority health objectives. The provision of essential drugs was mentioned as a priority by only 19 countries or 44 per cent. Since this seems rather low, it may be that such measures were subsumed in other programmes perhaps in the control of endemic diseases and immunization, and thus may have actually been considered more important by the governments.

The aim of this examination was to see the extent to which specific population and primary health care measures were included in the formulation of government policies. The notes to Table 3 show that efforts to control malaria were an important and widespread policy objective. Also of special attention were efforts to modernize hospitals, research, and training facilities and so forth.

This content analysis found that the principles of primary health care are at least being adopted by the African governments themselves in the formulation of their most recent health policies; this is itself a significant change from past strategies even though their vigorous implementation is as yet a reality in only a few countries. The investigation of stated objectives shows a striking move toward some of the principles of primary health care. 8/ Surprisingly little emphasis is given to curative medicines, medical research and hospital centres in the stated objectives although this is where most of the traditional funding has gone in the past. Analysis of government health expenditures in selected African countries in the early years of the 1970s showed that a very substantial percentage was spent for curative care. In 1971, over 80 per cent of the health expenditure for a number of African countries was spent upon curative care, 83 per cent in Kenya and approximately 86 per cent in Tunisia; while the rest was spent on preventive medicine, training, eradication of endemic diseases, etc. 9/

8/ See also Royaume de Maroc, Ministère de la Santé publique, Direction des affaires techniques, Les soins de santé primaites, Conférence internationale sur les soins de santé primaites, Alma-Ata-USSR, 1978; Secretariat of Health, Socialist People's Libyan Arab Jamahiriya, Primary Health Care Concept, 1978; Ministry of Health, the Democratic Republic of Sudan, The Status of Primary Health Care in Sudan, Khartoum 1978; Ministry of Health, the Democratic Republic of the Sudan, Primary Health Care Programme Sudan 1977/78 to 1983/84, Khartoum University Press, 1978.

9/ Health Sector Policy Paper, Washington, D.C., World Bank, 1975 pa. 76. See also Peter S. Heller, An Analysis of the Structure, Equity and Effectiveness of Public Sector Health Systems in Developing Countries: The Case of Tunisia 1960-1972. Discussion Paper No.43, Center for Research on Economic Development, the University of Michigan, Ann Arbor, 1975; Office of International Health, U.S. Department HEW, Syncrisis; The Dynamics of Health, and Analytic Series on the Interactions of Health and Socio-economic Development, XIV: ZAIRE., 1975; and A.A. Idriss, P.Lolik, R.A. Khan and A. Benyoussef, "Sudan: National Health Programme and Primary Health Care, 1977/78-1983/84", Bulletin, World Health Organization, Vol.53, 1976.

A majority of countries report that they had reviewed their development strategies in order to provide greater support for health care programmes. The diversity of the African experience is interesting and reflects a basic principle of the primary health care approach: that each country determines its own health system in the light of its political, social and economic realities and, as result, the mix of measures will necessarily vary. For example, Botswana reported that its major objectives are reinforcing primary health care services in rural and marginal urban areas and strengthening community participation; Burundi emphasized the training of its citizens with respect to preventive medicine; Egypt will concentrate on maternal child health services and providing potable water and housing in rural areas; Ethiopia, on the construction of health care stations, health centres and rural hospitals; Gabon, on improving hygiene, nutrition and rural housing; Kenya, on a Rural Health Programme and a "basic needs" approach; Madagascar, on the training of personnel, the distribution of medicine and sanitary facilities, and a better utilization of traditional medicine; Morocco, on campaigns against infectious diseases and malnutrition and the training of health care personnel; Nigeria, on an immunization programme; Rwanda, on increasing the number of health care centres; Sierra Leone, on strengthening maternal and child health services; Somalia, as well as Togo, on campaigns against infectious diseases.

Although different countries in the ECA region stressed different facets of the primary health care approach, their collective policies shared common principles. All of those countries which replied to the Fourth Inquiry reported measures designed to reach rural and underprivileged groups in their societies. For example, Botswana noted that it has been providing services to rural areas since 1973 and, at present, 80 per cent of its population is within one kilometer of a health care facility; Egypt is emphasizing maternal child health and nutrition activities, to be delivered by health units in rural and urban areas 10/; Gabon is setting up dispensaries in isolated zones; Ethiopia is constructing health stations and hospitals in rural areas and is training village health workers 11/; Ivory Coast is "regionalizing" its health care system and is making use of mobile health teams; Morocco is developing basic infrastructure and training sanitary personnel; Niger is organizing village health teams; Nigeria is currently establishing a pilot National Basic Health Scheme; Rwanda is establishing health care centres throughout the country; Seychelles is sending physicians and nurses to outlying areas; Sierra Leone is extending the activities of its Endemic Disease Control

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10/ Arab Republic of Egypt, Ministry of Health, Egyptian Experience in Primary Health Care, Cairo, 1978

11/ Ministry of Health, Primary Health Care Status in Revolutionary Ethiopia, Addis Ababa, 1978.

Unit and is training increased numbers of middle level personnel; Somalia is establishing mobile units to serve the nomaid population, while Togo is making similar use of mobile health teams. The experience of other African governments such as Tanzania, for example, have also made far-reaching efforts in the health care field. 12/

Among African countries there is an observable shift toward the primary health care approach. However, there is no consensus among African governments as to the efficacy of any one approach and some African governments criticized the increasing reliance on paramedical personnel in presentations at the 1978 Alma-Ata Conference. Nevertheless, important new principles are being articulated in African health policy and to the extent that they are implemented, they are likely to have profound demographic consequences. Though there remain many financial, administrative, political and perhaps structural constraints to the actual implementation of these health policy objectives, the new emphasis of these policies and measures will remain significant. 13/

ECLA

The countries of the ECLA region have achieved substantially higher levels of life expectancy than the ECA or ESCAP regions. However, progress in further reducing mortality has apparently slowed in a number of countries and this is causing some concern. Nineteen of the thirty ECLA countries consider their level of life expectancy to be unacceptable under their prevailing economic and social circumstances. Of the eleven governments considering it acceptable, three have levels above 70 years of age and six in the 62 to 69 years of age. None of the countries in the ECLA region had life expectancies of 50 years or less.

A number of countries in the ECLA region are developing health measures along the principles of primary health care, although their implementation has yet to be evaluated. 14/ All of the countries in the region reported that they had reviewed their development strategies to provide additional support to their health care programmes. These

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12/ The Ministry of Health, the United Republic of Tanzania, Primary Health Care Tanzania Experience, Dar es Salaam, 1978.

13/ WHO, Report of the Regional Director for Africa, WHO, International Conference on Primary Health Care, Alma-Ata, U.S.S.R. September 1978, ICPHC/ALA/78.4; See also, Oscar Gish, "The Political Economy of Primary Care and Health by the People: an Historical Explanation", Issue, A Quarterly Journal of Africanist Opinion, Vol. IX, No.3, Fall 1979 pp.6-13.

14/ WHO, Report of the Director, WHO. Regional Office for the Americas/Pan American. Sanitary Bureau. International Conference on Primary Health Care. Alma Ata, U.S.S.R., September 1978. ICPHC/ALA/78.5.

governments all reported that they had also adopted measures to reach underprivileged groups in their societies especially the rural populace. For example, the Bahamas established a net work of health centres, clinics and dispensaries throughout the islands, as well as a "flying doctor-dentist service in more remote areas". Colombia reported that it expects to improve the health of the country's population through income redistribution, tax reform, and an overall emphasis on social policies. In the short-term, however, the Government's Food and Nutrition Plan, its National Health Plan, and various programmes for Integrated Rural Development are expected to extend coverage to 36 per cent of the population which is not presently covered by health care services. The Dominican Republic reported that it intends to regionalize health care services, extend its programme of Basic Health Services, and train greater numbers of paramedical personnel. Ecuador's policy has a similar focus, emphasizing the extension of coverage to rural areas through the utilization of paramedical personnel and the staffing of rural centres by recent medical school graduates. Guatemala is focusing on the training of rural health technicians, and Honduras on a programme to provide basic infrastructure to remote areas and underprivileged groups. Mexico is currently seeking to bring health care programmes to the rural populace by means of the organised participation of rural groups. Additional measures include the creation of rural medical posts in communities of from 500 to 1,500 inhabitants--which will utilize local personnel trained in a basic needs approach--the extension of social security to the country's rural areas, and so on. Panama is building up an integrated health system, with auxiliary health personnel, while Peru is constructing hospitals in rural zones, training members of rural communities to attend to basic health necessities, and increasing qualified manpower in rural and marginal urban zones through the use of recent school leavers and paramedical personnel.

Cuba, as in the past, stands out as having a level of life expectancy far higher in relation to other countries in the region than its level of per capita income would suggest. It presently appears to have one of the highest life expectancies in the ECLA region. The extension of basic health services throughout the country has been noteworthy. The Cuban system as a whole has a pyramidal structure, with three hierarchical levels (central, provincial, regional) and five levels of services (national, provincial, regional, area, sector). The rural medical post is the smallest unit in the health sector, providing basic health services to between 3,000 and 5,000 inhabitants. Community participation is considered essential to the functioning of the health care system. Extensive vaccination programmes have been carried out through mass-based organisations. A rationing system provides a minimum of 2,650 calories per day to each of the country's inhabitants.

A number of other countries in the ECLA region are presently formulating mortality policies along the lines of the primary health care. 15/ Analysis of government health expenditures in selected Latin American countries in the early 1970s showed that a very substantial percentage was spent for curative services. Colombia which in 1979 had a total public expenditure in health of $203 million spent 79 per cent on curative and 19 per cent on public or preventive health efforts. Paraguay, which in 1972 spent $10 million on health, spent approximately 85 per cent for curative care. 16/ It remains to be seen how these new policy approaches will be reflected in additional financial allocation to and within the health sector.

ECWA

The rapid economic growth in many of the countries in the ECWA region has not so far been matched with corresponding primary health care implementation nor accelerated decline in mortality. Six of the twelve countries of the ECWA region consider their average level of life expectancy at birth to be unacceptable under prevailing economic and social conditions. Four of those countries have life expectancies of 50 years or less.

There is however, a strong tendency for the various ECWA countries to formulate policies designed to improve the conditions of the rural population and underprivileged groups. 17/ Baharain, for example, places an emphasis on the provision of decentralized polyvalent centres; Democratic Yemen has assigned high priority to maternal child health in in rural areas, giving special attention to the nomadic population and other inaccessible rural groups. Iraq reported that its current development

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15/ WHO, op.cit.. Ministerios de Bienestar Social, Secretaría de Estado de Salud Pública, atención medica Rural en la Provincia de Iujing, República Argentina, República Argentina, año 1978; Ministerio de Salud, República Peruana, Informe sobre atención Primaria de la Salud, Lima, 1978; Ministry of Health, Ministry of National Planning, Government of Costa Rica, Costa Rica Extension of Coverage of Health Services within the framework of Socio-economic Development, Cost Rica, 1978; Ministry of Health, Jamaica, Primary Health Care. The Jamaican Perspective, a Reference Manual for Primary Health Care Concepts and approaches in Jamaica, Kingston, 1978; Ministry of Health, Mexico, Program to extend Primary Health Services to the Rural Areas, Mexico City, 1978.

16/ World Bank, Health Sector Policy Paper, Washington, D.C. 1975, p. 76.

17/ WHO, Report of the Regional Director for the Eastern Mediterranean, WHO, International Conference on Primary Health Care, Alma-Ata, U.S.S.R., September 1978, ICPHC/ALA/78.6.

plan assigns high priority to health care facilities in rural zones. Jordan, which reported that it would upgrade basic health care services beginning in 1978, will focus on the expansion of preventive services for the rural and nomadic population and for lower income urban groups. Oman is concerned with the equal provision of basic services in both urban and rural zones. Saudi Arabia is focusing on the extension of health care programmes to the rural and nomadic population, on preventive services, health education, and programmes of maternal child health. The Syrian Arab Republic reported efforts to provide rationally distributed health care institutions; furthermore, as a means of providing improved coverage of the rural population, physicians will be encouraged to work in remote and underprivileged regions. Yemen similarly has assigned priority to the establishment of preventive services in rural zones.

ESCAP

Of the 33 countries in the ESCAP region 23 consider their average level of life expectancy at birth to be unacceptable under the prevailing economic and social circumstances. Five of the remaining ten Governments which consider their mortality levels acceptable have life expectancies of 70 years of age or older. On the other hand, nine countries still have the unacceptable life expectancies of 50 years or less.

A number of ESCAP countries (Bangladesh, Fiji, Iran, Pakistan, Philippines, Sri Lanka and Thailand) have identified quantitative targets for the reduction of morbidity and mortality, targets which are usually expressed in terms of reducing crude death rates and infant mortality rates by a certain number of percentage points per annum; in addition, several countries have identified targets for the reduction of malnutrition and various endemic diseases (tuberculosis, gastroenteritis, malaria, schistosomiasis etc).

There is generally a better integration of health-related policies within overall development plans in the ESCAP region than in the other regions. 18/ A number of ESCAP countries have emphasized that their national health policies have been fully integrated within their comprehensive development plans. Health care planning is an especially important component in the development plans of Bangladesh, China, India, the Philippines, Sri Lanka, Thailand and Japan. The ESCAP countries tend to

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18/ WHO, Report of the Regional Director for South-East Asia, WHO, International Conference on Primary Health Care, Alma-Ata, U.S.S.R., September 1978, ICPHC/ALA/78.8; WHO Report of the Regional Director for the Western Pacific, WHO, International Conference on Primary Health Care, Alma-Ata, U.S.S.R., September 1978, ICPHC/ALA/78.9.

be more uniformly anti-natalist than other regions, and it is important to note that a number of countries stress the role that family planning has assumed in health-related programmes.

However, a number of similar difficulties with conventional health and mortality policies have been identified by governments in the region: 19/

" a. They are hospital based and disease-oriented.
b. They are entirely dependent on borrowed foreign technology, leading to over-sophistication, thus making them ill-suited to the needs of the rural community.
c. Attitudes, skills and approaches of trained personnel are entirely unrealistic. In short, it is a cure-oriented system as opposed to a system intended to keep the population healthy.
d. Health services are viewed as an end in themselves.
e. They are inaccessible to a large part of the population in physical, social, cultural and financial terms.
f. There is lack of community participation in health activities. The system is impervious to consumers' influence. "

In response there has been an increased emphasis on a primary health care approach in the ESCAP region. Bangladesh, for example, is currently building up a health care infrastructure in all rural "thanas", to strengthen its training programme for middle health workers and field personnel, to set up pharmaceutical units for the production of essential drugs, to encourage the development of traditional medicine etc. In the ESCAP region as a whole, there is also increasing emphasis on programmes to reach underprivileged groups, such as women, children, and, in particular, the rural populace The Philippines is presently re-organizing its total health delivery structure, setting up a "barrio" health system and providing additional midwives in rural areas; Thailand is undertaking a number of efforts including the training of a larger number of para-medics and making efforts to provide potable water to every village. 20/ India is emphasizing the provision of health care to vulnerable groups, such as children, pregnant women and lactating mothers, through a Minimum Needs Programme; it will give preferential treatment to "backward and tribal areas which have so far been neglected".

19/ Ministry of Health and Family Welfare, Primary Health Care in India, New Delhi, 1978.

20/ Ministry of Public Health, the Royal Thai Government, Primary Health Care in Thailand, Bangkok, 1978; Ministry of Public Health, The Royal Thai Government, Lampag Health Development Project, Bangkok, 1978.

Lessons can be drawn from the Indian efforts to promote delivery policies in conjuction with their primary health care programmes. The Government has identified the following essential premises, which are also typical of many other developing countries. 21/

" a. That the majority of health problems of this country lie in the villages and poorer sections of the city where the vast majority of our population lives.

b. That the cultural factors in health and the cultural affinity of health workers to the community they serve is more important than technical expertise.

c. That most of the health problems at the village level can be tackled at that level, by workers appropriately trained from among the villagers.

d. Most common illnesses are simple to diagnose and can be treated effectively with cheap and safe drugs especially when detected early; neglected, they become complex and expensive problems.

e. That the medical profession by virtue of its cultural background, training and aspirations, cannot understand or function effectively in the context of village health problems.

f. That in a country of our size, no matter how intricate a health system is devised, the problem of adequate supervision of workers will always remain; under these conditions, the only effective supersision of workers must come from the community itself.

g. In order to play the above role effectively, the community must become fully aware of its health problems and understand the roles of the various workers who will be responsible to the members of the community.

h. The public, as well as the medical profession, confuse illness with health. The two are diametrically opposite. The ancient belief that health is a positive state of physical, social and mental well-being which is so well emphasised in our indigenous systems of medicine be revived. "

21/ Ministry of Health and Family Welfare, Primary Health Care in India, New Delhi, 1978.

The State of Kerala has substantially reduced both mortality and fertility levels through various broad based programmes even though its level of economic growth has not been great. 22/

The case of Sri Lanka, is particularly important because it has achieved dramatic progress in reducing levels of mortality and morbidity without rapid economic growth. A nation with a highly structured health care programme, Sri Lanka reported that it provides free medical care to its entire population. The locational aspects of health care programmes have been given important consideration and, on average, a persons does not have to travel more than 3 miles to reach a free public health facility. Anemia and malnutrition have been treated through what the Government has termed a "package type of family programme ". Nutritional supplements have been an important part of the Government's health care programme and some 50 per cent of Sri Lanka's population receive a subsidized food ration which provides up to half of their daily caloric and protein intake.

China's health policies have been particularly impressive. Within the context of a profound social revolution, self-reliant, community based health efforts were extended across the world's largest population resulting in very substantially reduced mortality and morbidity. This remarkable effort has served as an impetus to the primary health care efforts in many other countries and adaptations of the Chinese "barefoot doctor" in particular are being reflected in village health worker programmes throughout the developing world. 23/

Emerging policy trends, issues and problems

Among the more developed countries, concern continues over the substantial differentials in mortality of various groups and social classes. Of particular concern is the excess mortality of adult males and the gap between male and female mortality at the older ages. New preventive measures are being instituted in this regard to reduce deaths associated with tobacco smoking, excessive drinking, overnutrition, insufficient excercise and stress.

22/ See John Ratcliffe, "Social Justice and the Demographic Transition: Lessons from India's Kerala State", International Journal of Health Services, Vol. 8, No. 1, 1978.

23/ WHO, UNDP, "Study Tour on the Training and Utilization of Barefoot Doctor in Community Health Services in the Peoples Republic of China", Technical Completion Report, Geneva 1978, INT/78/034.

A curative approach with its high technology and the required advanced medical training has contributed to a rapid escalation of health costs. In many developed countries these costs have risen more rapidly than those of any other sector. Partly as a result of this, some of the principles of primary health care which are being adopted in developing countries are being adapted to the more developed countries as well. In this connection there is also a greater interest in the utilization of paramedical personnel; more attention to involving the consumer to participate, both collectively and individually, in the planning and implementation of health care; and a greater attention to integration of health care with the preventive, primary, and social service efforts.

The links between changes in health conditions and changes in governmental expenditure in health are exceedingly complex. Of course changes in the proportion of the G.D.P. spent on health services are much less likely to be reflected in changing health conditions than are changes in the level of living itself. Health and medical care are often financed by expenditures of individuals and/or by private institutions. As already mentioned, among the developed countries with market economies, government expenditure on health services averaged 2 per cent of the Gross Domestic Product in the mid 1970s, however, as mentioned earlier, 5 per cent or more was spent by the Federal Republic of Germany, New Zealand, Norway and the United Kingdom. 24/ In the more developed centrally planned economies health services are generally granted free of cost for the individual. The USSR, as well as a number of other European countries, have long practised many of the health policies now being formulated by the developing countries. In general, they were implemented without demographic rationale, although it is expected that an accelerated decrease in mortality will contribute to the desired level of the population growth.

The actual implementation of primary health care is expected to produce profound changes in many developing countries. There is widespread dissatisfaction with earlier approaches and a broad new consensus is emerging with many countries supporting the concepts and principles of

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24/ United Nations, Department of International Economic and Social Affairs, Patterns of Government Expendite on Social Services; Supplement to the 1978 report on the World Social Situation, ST/ESA/87/Add.1., p. 35.

primary health care. 25/ Such policies, in addition to their possible explicit demographic objectives, are likely to have profound demographic consequences even if they are only partially implemented.

Countries from all regions are formulating new principles to incorporate into their national policies and development strategies. Relevant, low-cost and accessible health care provided by a high degree of community participation and promoted within integrated social and economic efforts was unanimously supported by the Alma-Ata Conference on Primary Health Care in September 1978 organized by WHO and UNICEF.

A significant impetus for the primary health care movement has come from the international recognition of the successful efforts of the Chinese in this field. Their community based health efforts, their self-reliance principles, and their "barefoot doctors", are being adapted and adopted in many parts of the developing world. Of course these measures occurred within the context of a profound social revolution and the success, both the implementation and the health impact must be judged in this light. Thus the Chinese success in implementation and impact has come from fundamental social restructuring, a profound redistribution of income and agricultrual land, substantial mobilization to improve environmental health, as well as specific health care measures.

The United Nations Water Conference of Mar de Plata in Argentina in 1977 which designated the 1980s as a Decade for Drinking Water and Sanitation and urged the ambitious goal of safe drinking water and hygienic conditions for all by 1990, has also focused attention on environmental health efforts. It is estimated that current investments in drinking water and sanitation must be nearly doubled in urban areas to attain these goals. These investments could be considerable, tube-

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25/ Primary health care has been defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford..."(it) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitatitve services accordingly;..(and) includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs". See the "Declaration of Alma Ata", from the WHO/UNICEF International Conference on Primary Health Care: Report on the International Conference on Primary Health Care, Alma-Ata, U.S.S.R., 6-12 September 1978, (Geneva: World Health Organization, 1978).

wells and stand-pipes might cost an average of U.S. $10 per person in rural areas, and with house connections, these costs could range from $75 to $150 per person. Sanitation facilities in rural areas are estimated to cost around $5 per person while in urban areas the cost could range from $15 to $200 with sewer systems. The necessary infrastructure must also be developed to maintain these services at the community level. Without substantial mobilization of domestic and international resources, safe drinking water and hygienic conditions for all will be an unattainable objective in the developing countries. However, the new recognition of its crucial importance within environmental health strategies as well as overall development efforts, is certainly significant. Even a partial implementation of these programmes may have a significant demographic impact.

Declines in infant mortality may have slowed or halted in some developing countries. Progress in further reducing mortality has been less than satisfactory and there is overwhelming evidence that infants and children under five years of age, from the lowest income groups, suffer the greatest mortality loss. 26/ These high infant mortality rates are in large part a result of gastroenteritis and diarrheal diseases which are not being effectively treated by traditional public health and curative medicinal practices. In many rural and urban settings environmental health conditions are being viewed as a prerequisite for substantially reducing mortality.

The 1979 International Year of the Child focused widespread attention on children's health and well-being especially in developing countries. Concern that infants and children represented the largest proportion of deaths in the developing world led to some national evaluations of efforts being done on their behalf. Issues were raised in many countries about the quality, level and coverage of maternal and child health services. But broader questions were also raised about the quality of children's environmental health, their nutrition and nutritional practices, their access to safe water, sanitation, elementary education and housing. Thus, in many countries, the activities relating to the 1979 International Year of the Child gave additional emphasis to the primary health care movement.

The World Population Plan of Action recommended that "health and nutrition programmes designed to reduce morbidity and mortality be integrated within a comprehensive development strategy and supplemented by a wide range of mutually supporting social policy measures; special

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26/ D.R. Gwatkin, "The End of an Era, Recent Evidence Indicates an Unexpected Early Slowing of Mortality Declines in Many Developing Countries", Overseas Development Council (Washington, 1979).

attention should be given to improving the management of existing health, nutrition and related social services and to the formulation of policies to widen their coverage so as to reach, in particular, rural, remote and underprivileged groups". 27/ The World Plan of Action also recommended "the reduction of infant and child mortality particularly by means of improved nutrition, maternal and child health care and maternal education". 28/

There is an accumulation of scientific evidence relating important links between poverty, nutrition of pregnant and lactating women, family planning, breast feeding practices, sanitary and supplemental infant feeding, birth intervals, and child mortality associated with diarrhea and lower respiratory tract infections. 29/

The principles of primary health care policies are to a large extent scientifically based. While there are debates about the mix of measures which vary greatly according to the health situations of particular countries and communities, many of the basic principles share an uncommonly wide support among health scientists. Programmes to control communicable diseases, including cholera and malaria, have contributed to longer life expectancies in developing countries. But the conditions of environmental health, poverty, malnutrition, poor sanitation and hygiene are more intractable. Modern drugs and curative medicine may be very effective in providing immediate relief, and in some cases an eventual cure, but often when a patient returns to a disease-ridden area, reinfection is likely. The environmental health conditions challenge the limits of curative medicine even when the services do reach the population.

Although there is strong scientific support for many of the principles of primary health care and widespread support by the international health community, there is often insufficient political support for these programmes to be fully implemented. Perhaps in no other area of policies affecting population, is there such unanimity of principles among the scientific community, the international community, as well as governments themselves. Nevertheless, the degree of commitment from many governments remains relatively small and thus, the political

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27/ United Nations, Report of the United Nations World Population Conference, 1974, New York 1975, p.8 para. 15.d.

28/ Ibid., p. 12, para, 32.a.

29/ Grosse, Robert N., "Interrelation Between Health and Population Observations Derived from Field Experiences", Background Papers, Health and Population in Developing Countries, Bellagio, 1979; H. Hansluwka, "Health, Population and Socio-Economic Development", in Léon Tabah, Population Growth and Economic Development in the Third World, IUSSP, Liège, pp. 191-249; Winikoff, Beverly, "Nutrition, Population and Health: Some Implications for Policy". Science. Vol. 200, May 1978, pp. 895-902.

dimensions of health strategies - how they are formulated, financed and implemented - is of increasing importance.

The over-emphasis on individual curative medicine, with its relatively high cost and low health benefits has been attributed to the professional bias of physicians; to the political power of the urban elite who have already met their own environmental health needs; and to the nearly universal and immediate demand for curative medicine when it is needed. The overcapitalization in curative hospital services has also reflected past domestic and international interests for visible national symbols. In any case, the access of a population to medical care is severely reduced by both economic barriers and by the uneven geographic distribution of such services.

At present only a very limited proportion of the population in developing countries has access to public health services, clean drinking water, adequate nutrition, sanitation, and other environmental and preventive health measures. However, a new emphasis is emerging which targets primary health care to high risk groups, especially to children, women in the reproductive ages, and to the underprivileged in both rural and urban areas. Priority is being placed upon environmental health efforts and to the non-medical determinants of health. New consideration is being given to the importance of potable water, proper nutrition, improved sanitation, health education, maternal and child health care, including family planning, as well as other measures to immunize against the major infectious disease, and to control locally endemic diseases. This spirit also involves the greater use of paramedical personnel in simpler decentralized services where the health needs are greatest. The United Nations monitoring of health, morbidity, mortality and population policies showed an interesting new mix of measures in different countries reflecting a diversity of health conditions as well as social, economic and political realities. But a basic shift in health care philosophy is being articulated in all regions of the developing world and despite the many constraints and difficulties in implementing such measures, the widespread recognition of their necessity is significant.

There is a growing recognition by Governments that many of the most important determinants of health and mortality are non-medical, and fall outside the traditional activities of the Ministries of Health. This new awareness that health policies should be integrated within overall socio-economic development plans is being articulated by many countries which are formulating health and mortality programmes in education, food and agriculture, water and sanitation, community and rural development, and other related areas. The synergistic benefits of a unified integrated approach are being appreciated.

However, the institutional, political and economic constraints to such integrated policy approaches can also be substantial. Integrating these approaches in sectoral and national development plans, though not insurmountable, does often involve competing institutions, departments and ministries whose traditional activities and interests often compete for priority. At the local level, operational problems are being faced about how to effectively integrate specific health programmes, such as maternal and child health care and family planning with community and rural development projects. In many ways these integrated policies are more efficient, but on the other hand the benefits of specialization are sometimes lost by such steps. In some countries the delivery systems are being overloaded with long agendas of projects. The integration of these programmes is often easier at the national level than at the village level.

A number of governments are designing programmes to allow greater local initiative, control and supervision of village health workers. Increasingly the community, rather than national or regional supervision of local health projects is seen as a more effective method of obtaining responsive and caring services. Their involvement in both the formulation and implementation of health activities and the determination of community needs is often being given greater importance. In many countries a greater reliance is being placed upon community resources to help support these programmes. An increasing number of countries are involving traditional practitioners, whose effectiveness varies widely, by giving them elementary training, supplies, and referral systems. As mentioned earlier, recent experiences gained from the Indian efforts to promote health delivery policies in conjuction with their primary health care programmes have identified and number of essential premises which are typical of many countries.

The use of community health workers has been shown to be feasible not only in China but also in such countries as Botswana, Brazil, India, Iran, Jamaica and Tanzania. However, there can be ample difficulties in administering such an infrastructure, especially in training and recruitment, in supervision and the provision of supplies. The balance among the levels of the health care systems, the community activities, referral services and hospital facilities; among primary, preventive, and curative approaches, will continue to be important issues with financial, administrative, and political dimensions.

Poor nutrition is an underlying or associated factor in many of the deaths from infectious diseases among children. In one study of infant and childhood mortality in Latin America, half of the cases were associated with malnutrition. 30/ Food subsidy programmes have contributed to reductions in mortality, as in Sri Lanka where in 1974,

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30/ Puffer R.R., Serrano C.V., Patterns of Mortality in Childhood Pan American Health Organization, Washington, D.C. 1973.

when the effort was reduced, there followed a temporary increase in deaths until food became more plentiful in 1977. Food subsidies for the general population, while potentially effective in reducing mortality can, however, be very expensive to maintain, especially as it may not be politically acceptable nor administratively feasible to restrict subsidies to those most undernourished. Experimental projects for supplementary feeding schemes to young children and pregnant and lactating mothers have also proved to be relatively expensive. 31/ The most important policies affecting malnutrition remain those which reduce poverty and increase food production per person. It is in this sense that one of the main underlying causes of death is fundamentally related to the process and structure of development. According to one analysis, the past increases of life expectancy in developing countries between 1935-1940 and 1965-1970 are attributed roughly equally to public health efforts and to social and economic development. 32/

Actual implementation of primary health care programmes in the third world will require the mobilization of substantial domestic and international resources. Currently, overall government health expenditures in developing countries are not great, they amount to less than two per cent of the gross national product, although private expenditure may be much higher. The greatest proportion of these public funds are spent on curative medicine which is reaching only a narrow segment of the population. Policy analysis is needed to assess the cost effectiveness and feasibility of various specific policy interventions and the relationships between those policies aimed at fertility, morbidity and mortality. 33/. "In most developing countries, the bulk of the deaths are of children under five years of age. In general, the higher the overall mortality in a country, the larger the proportion of deaths are of children of such ages... . Significantly, it is precisely in this age-group that reductions in mortality have been relatively slow while the casuses of mortality remain largely preventable at fairly low cost ". 34/

31/ Taylor C.E., Kielmann A.A., Parker R.L., et.al., Malnutrition, Infection, Growth and Development: The Narangwal Experience: Final Report, Washington, D.C., World Bank, 1978.

32/ Samuel H. Preston., "Causes and Consequences of Mortality Declines in Less Developed Countries during the Twentieth Century", paper presented to the National Bureau of Economic Research Conference on Population and Economic Change in the Less Developed Countries, 30 September-2 October 1976, pp. 21-25.

33/ Habicht, Jean-Pierre and Peter Berman, "Planning Primary Health Services from a Body Count?" Background Papers, Health and Population in Developing Countries, Bellagio, 1979; Morrison, Peter, "The Future Demographic Context of the Health Care Delivery System", A RAND NOTE, Santa Monica, 1979; Kunstadter, Peter, "Interactions of Child Mortality with Maternal Parity: Some Implications for Population and Public Health Policy", 1978 mimeographed.

34/ Robert N. Grosse, "Health and Population in Developing Countries", Background Paper on Health, Bellagio, Italy, 1979, p. 15.

A number of specific policy measures already exist which could have significant impact upon infant and child mortality but they still require certain investments in infrastructure to be effective. Oral rehydration techniques can inexpensively reduce the infant and child diarrhea related deaths. However, the rehydration mixtures themselves require potable water as a pre-condition for effective use, thus the cost effectiveness of these measures may be related to hyhienic practices and drinkable water. Many infant and child deaths could be eliminated by immunization programmes, especially measles vaccinations. These are simple techniques and inexpensive measures that can be undertaken by para-medical personnel which could have significant, potential demographic impact. However, to be most effective, these vaccines must be kept in constant refrigeration from the supplier to the infant, and because they are often not, many children are being immunized with ineffective vaccines. Maintaining a continual cold chain thus requires a sufficient infrastructure to reach the underserved rural populations and again, underscores the fundamental preconditions for even the most simple medical techniques.

A study analysing pilot projects in Guatemala, Nigeria, Peru, Turkey, India, Jamaica and Iran suggests that efficiently administered nutrition and primary health care programmes can "reduce infant and child mortality rates by one-third to one-half within one to five years. " 35/ Some estimates suggest that such programmes could be widely implemented at a cost of one to two per cent of the per capita Gross National Product, a figure similar to the current expenditure by governments on health services.

Arguments are emerging for a more selective interim strategy on primary health care, involving the establishment of priorities for disease control based upon their prevalence, mortality, morbidity and the feasibility of control. Instead of attempting to achieve comprehensive health services for all, some are calling for a narrow interim concentration on a few important diseases with selective crucial intervention.

Table 4 represents one recent effort to assign priorities for disease control in developing countries upon the criteria of prevalence, mortality, morbidity and feasibility of control. 36/ No doubt there will be disagreement with the priority ranking of disease control efforts, but

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35/ Davidson R. Gwatkin. "Toward a Population Strategy for the 1980s," mimeo May 1979, p.3; and Davidson R. Gwatkin, Janet R. Wilcox, and Joe D. Wray, Can Interventions Make a Difference? The Policy Implications of Field Experiment Experience. A Report to the World Bank, March 1979. Mimeo.

36/ Julia A. Walsh and Kenneth S. Warren, "Selective Primary Health Care, An Interim Strategy for Disease Control in Developing Countries", The New England Journal of Medicine, Vol.301, Number 18, November 1, 1979, p. 973.

Table 4 Priorities for disease control in the developing world, based on prevalence mortality, morbidity and feasibility of control.

Priority Group	Reasons for assignment to this category
I High	High prevalence, high mortality or high morbidity, effective control
Diarrheal disease	
Measles	
Malaria	
Whooping cough	
Schistosomiasis	
Neonatal tetanus	
II Medium	
Respiratory infections	High prevalence, high mortality, no effective control
Poliomyelitis	High prevalence, low mortality, effective control
Tuberculosis	High prevalence, high mortality, control difficult
Onchocerciasis	Medium prevalence, high morbidity, low mortality, control difficult.
Meningitis	Medium prevalence, high mortality, control difficult
Typhoid	Medium prevalence, high mortality, control difficult
Hookworm	High prevalence, low mortality, control difficult
Malnutrition	High prevalence, high morbidity, control complex
III Low	
South American trypanosomiasis (Chagas' disease)	Control difficult
African trypanosomiasis	Low prevalence, control difficult
Leprosy	Control difficult
Ascariasis	Low Mortality, low morbidity, control difficult
Diphtheria	Low mortality, low morbidity
Amebiasis	Control difficult
Leishmaniasis	Control difficult
Giardiasis	Control difficult
Fialariasis	Control difficult
Dengue	Control difficult

Source: Julia A. Walsh and Kenneth S. Warren, "Selective Primary Health Care, An Interim Strategy for Disease Control in Developing Countries". The New England Journal of Medicine, Volume 301, Number 18, November 1, 1979, p. 969

the general framework should provide a methodology by which alternative priorities can also be advocated an their reasons specified. 37/ While recognizing the importance of regional variations among developing countries, the Walsh and Warren study assigned the highest overall priority to the control of the following diseases: diarrheal disease, measles, malaria, whooping cough, schistosomiasis, and neonatal tetanus.

Table 5 presents Walsh and Warren's estimated annual costs of different systems of health intervention on a per capita basis, and by their estimated cost per averted infant or child death. Their selective primary health care interventions are designed for the priorities of disease control given in Table 4. Walsh and Warren search for the least expensive interventions, on both a per capita basis and in regard to the cost per infant/child death prevented. They attach especially high priority to a target population of children up to three years of age, and women in their reproductive ages. Specific health interventions upon which they place highest priority are: child vaccinations for measles and diptheria-pertussis-tetanus (DPT), tetanus toxoid for all women in reproductive ages, health education for long-term breast feeding, wide dissemination of chloroquine for young children subject to episodes of malaria fever, and a programme for the instructions and distribution of oral rehydration packets. They estimate that if half of all children and their mothers and half of the preganant women were included in such a programme, that deaths from measles would decline by 50 per cent, whooping cough by 30 per cent, neonatal tetanus by 45 per cent, diarrhea by 25 to 30 per cent and malaria by 25 per cent.

The callenge of these mortality policies lies not with their formulation but with their implementation; a broad based policy may be most effective in reducing mortality, but it may also be the most difficult to implement. An emphasis on the rural areas and urban underprivileged is clearly called for because it is there, where the health demand is greatest. But the infrastructure, the training and management of personnel, the cost of delivering services to remote areas and to develop them where few exist is difficult. There are substantial overhead costs to these structures which must be maintained over time. Fortunately, many of these problems are being anticipated in the formulation of the policies.

The implementation of these programmes will require substantial funding. Will these funds be raised from existing revenues? To what extent will these funds be transferred within the health sector or from other sectors? Analysis of government health expenditures in selected countries shows that in the early 1970s, Kenya, Paraguay, Tunisia, Colombia and Venezuela, all spent more than 75 per cent of their government health expenditures upon curative care and only a small fraction on

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37/ Ralph H. Henderson and Jacobus Keja, "Selective Health Care for Developing Countries, to the Editor", The New England Journal of Medicine, Vol. 302, No. 13, 27 March 1980, p. 758.

Table 5 Estimated annual costs of different systems of health intervention

Interventions	Per Capita cost b/ US$	Cost per infant and/ or child death averted a/ US$
Base primary health care a/		
Range	0.40-7.50	144-20.000 (I)
Median	2.00	700
Mosquito control for malaria	2.00	600 (I)
Onchocerciasis control program	0.90	Few infant and child deaths
Mollush control for schistosomiasis	3.70	Few infant and child deaths
Community water supplies and sanitation	30-54	3600-4300 (I.C.)
Narangwal nutrition supplementation	.75	213 (I) 3000 (C)
Selective primary health care c/	0.25	200-250 (I.C.)

a/ Denotes infant and child
b/ Delivered by village workers
c/ In this case, delivered by mobile units.

Source: Julia A. Walsh and Kenneth S. Warren, "Selective Primary Health Care, An Interim Strategy for Disease Control in Developing Countries". The New England Journal of Medicine, Volume 301, Number 18, November 1, 1979, p. 973.

primary care . 38/ New efforts are now being made to measure the financial allocation both to and within the health sectors of many countries 39/ to determine the degree of commitment and implementation of these policies; other indicators are also being developed to measure the progress toward these health policy objectives. 40/.

The implementation of comprehensive primary health care is in many respects resting on the preconditions of development and the alleviation of poverty. The alleviation of poverty has often proved most difficult for powerful economic, social, and political reasons. As the nonmedical determinants of health receive higher priority, additional support may be given to the provision of these fundamental needs. But often there are significant financial, administrative, political and structural constraints to the provision of the nonmedical determinants of health. However, China, Sri Lanka, Cuba, the Indian state of Kerala to name a few, have had a spirit of broad based environmental health efforts which have contributed to and substantially lowered mortality and fertility. These countries have also experienced varying degrees of social restructuring, and mortality and fertility levels are apparently responding favourably to these synergistic effects.

Conclusion

Population policies are closely related to measures which affect health and mortality. Policies which lessen morbidity and mortality, increase the natural rate of population growth and affect fertility in various ways. Over time, there are complex interrelationship among, for example, infant and mortality and fertility and the rate of population growth. These are complimented by the often close relationships among population policies,

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38/ World Bank, Health Sector Policy Paper. Washington D.C. 1975, p. 76; World Bank, Health Sector Policy Paper, Washington, D.C. 1980.

39/ WHO, Financing of Health Services, Report of a WHO Study Group, Technical Report Series 625, Geneva, 1978; Zschock, Dieter K., Health Care Financing in Developing Countries, American Public Health Association, International Health Programmes, No. 1, Washington 1979; Office of International Health, U.S. Dept. of H.E.W. An Approach to the Study of Health Sector Financing in Developing Countries: A Manual., Washington, 1978.

40/ Davidson R. Gwatkin and James P. Grant, "Using Targets to Help Improve Child Health", Paper prepared for the Fifth International Health Conference: Child Health in a Changing World", crganized by the National Council for International Health in conjunction with Columbia University. New York, 14-17 May 1978.

health policies and the level and distributive character of development efforts. Also of particular importance is the overlapping high risk target groups - infants and women of reproductive ages. Of particular importance the measures on family health, maternal and child health care, including family planning. These policies linked with the emerging principles of primary health care with its emphasis on the non-medical determinants of health and the widening of the population access to better environmental health conditions. Policies affecting the spatial distribution of the population may also compliment the decentralization of medical services as well as the extension of health programmes to the rural areas.

Although average life expectancies in the more developed countries have reached unprecedented levels, nine of the thirty nine countries still consider their levels as unacceptable under their prevailing, economic and social circumstances. Concern over mortality differentials among various groups and social classes and the excess mortality among adult males is being reflected in various preventive health measures.

In developing countries mortality levels have improved considerably over the past few decades, but still lag far behind levels of the more developed countries. Ninety eight of the 126 developing countries consider their level of life expectancy to be unacceptable even under their prevailing economic and social circumstances. Mortality levels are seen as least acceptable in the ECA region (49 out of 51 countries); followed by the ESCAP region, the ECLA region, and the ECWA region.

Major changes are occurring in the formulation and implementation of health policies among developing countries and a broad consensus is emerging which supports the principles of primary health care. Though many of these programmes are not explicitly motivated for demographic purposes, they are likely to have profound demographic consequences to the extent that they are actually implemented. Many of the newly stated objectives are ambitious, facing formidable financial, administrative, and political constraints closely linking them to the structure of development; while others are seeking more selecting crucial interventions based on priority rankings of disease control efforts and then feasibility.

Chapitre 19

FECONDITÉ

Introduction

L'évolution de la fécondité au cours des dernières années s'est caractérisée par deux tendances d'intérêt primordial dans le domaine des politiques de population. Dans les pays développés, la baisse de la fécondité s'est poursuivie au point que des soldes négatifs de naissances par rapport aux décès, et plus nombreux encore des taux de reproduction nets inférieurs à l'unité, sont devenus fréquents parmi ces pays. Dans les pays en développement, près des deux tiers de la population de ces régions sont entrés dans un processus de baisse de la fécondité plus ou moins rapide. Seul un tiers de la population de ces régions connaît encore des niveaux de fécondité élevés et stables.

Les perceptions que les gouvernements adoptent à l'égard de la fécondité peuvent être examinées à deux points de vue: d'une part, pour leur effet global sur les niveaux et les tendances du taux d'accroissement naturel, et d'autre part, pour leur effet sur le bien-être des familles et des individus. Désignons ce dernier plan d'analyse comme celui de la fécondité "individuelle".

Les perceptions gouvernementales ayant trait à la fécondité "individuelle" peuvent être considérés sous plusieurs aspects: premièrement, l'aspect de la santé, en particulier celle de la mère et ses conséquences sur le bien-être général de la famille; deuxièmement, l'aspect des droits de la personne, en particulier le droit des individus de décider librement du moment et du nombre d'enfants qu'ils désirent avoir; troisièmement, l'aspect social et socio-légal qui inclut les droits mais aussi les obligations sociales et socio-légales des parents, des enfants, et de la famille en général; et quatrièmement, l'aspect des relations entre la fécondité et le statut de la femme.

Les perceptions gouvernementales ayant trait à l'aspect global de la fécondité, comme c'est le cas pour les perceptions relatives au taux d'accroissement naturel, dépendent du solde net des avantages et des inconvénients attendus d'un niveau de fécondité globale. Cependant, si cette perception est assez semblable à celle adoptée à l'égard du taux d'accroissement naturel, elle ne coincide pas nécessairement avec la première puisque celle-ci porte sur l'évaluation d'un processus dans lequel interviennent plusieurs composantes. Bien entendu, des relations étroites existent entre fécondité "individuelle" et fécondité "globale": la polarisation progressive de comportements "individuels" autour de certaines normes de procréation peut conduire à des niveaux de fécondité "globale" jugés non satisfaisants par les gouvernements. La formation de ces perceptions déterminent, en dernier ressort, l'adoption ou non d'une politique et ses modalités d'application. En matière de fécondité, la plus ou moins grande importance accordée à l'aspect du bien-être individuel plutôt qu'à l'aspect démographique déterminera largement le type de mesures adoptées.

Avant d'analyser les perceptions et les politiques par niveau de développement et par région, donnons un bref aperçu de la situation à l'échelle mondiale dans le contexte de l'évolution de la fécondité.

Au niveau mondial on note en 1980 que le taux net de reproduction, qui exprime combien une femme mettra de filles au monde compte tenu des conditions de mortalité et de fécondité, s'élève à 1,54 fille par femme. Le déclin de ce taux est maintenant rapide, car en 1975 il était encore de 1,61, et est dû essentiellement durant cette période à la baisse de fécondité dans les pays en développement: le taux s'est en effet maintenu à 0,95 dans les pays développés alors qu'il tombait de 1,86 à 1,74 dans les pays en développement. Au niveau régional, non seulement le taux reste élevé en Afrique, mais c'est aussi la seule région du monde où il est en augmentation: de 1975 à 1980, il est passé de 2,24 à 2,27. En Asie, le taux est inférieur à 2 pour l'ensemble de la région et dans chacune des sous-régions. Le déclin a été particulièrement important en Asie orientale, le taux étant passé de 1,32 à 1,09 durant les 5 dernières années. En Amérique latine, la décroissance est plus lente et la situation plus hétérogène: le taux s'élève encore à 2,56 en Amérique centrale, mais est tombé à 1,30 en Amérique du Sud tempérée.

En Europe, le taux a encore diminué, mais le déclin marque quand même le pas: il est passé de 0,93 à 0,92 de 1975 à 1980. L'Europe occidentale avec un taux qui parait stabilisé à 0,78 représente la sous-région ayant le plus bas taux du monde. On assiste à une légère remontée du taux en Amérique du Nord, de 0,86 à 0,92, tandis qu'il reste stable à 1,10 en URSS.

En 1980, la moitié des pays se déclarent satisfaits de leur taux de fécondité (84 sur 165) et dans l'autre moitié, 22 perçoivent leur taux trop bas et 59 l'estiment trop élevé.

Dans les pays développés, 8 pays sur 39 considèrent leur niveau de fécondité trop bas, 31 satisfaisants et aucun trop élevé. Dans les pays en développement, la répartition est pratiquement inversée: 14 pays sur 126 considèrent la fécondité trop basse, 53 satisfaisante et 59 trop élevée (cf tableau 1). Très peu de pays ont changé leur perception depuis 1978: le nombre de pays satisfaits du taux reste le même ainsi que celui des pays non satisfaits parce que le taux est trop bas. L'augmentation du nombre de pays qui estiment leur fécondité trop élevée est due principalement à l'arrivée dans ce groupe de la plupart des pays devenus indépendants depuis 1978. La perception d'une situation non satisfaisante n'implique pas que les gouvernements soient décidés à intervenir pour modifier cette situation. Au niveau mondial, 17 pays, parmi les 22 qui jugent leur fécondité trop basse, interviennent pour modifier le taux, et 38 parmi les 59 qui la jugent trop élevée. Parmi les 84 pays satisfaits de leur taux, 31 interviennent pour maintenir le taux à son niveau actuel, jugé satisfaisant.

Dans les pays développés, 7 pays parmi les 8 qui jugent leur fécondité trop basse, interviennent et dans les pays en développement, 10 parmi les 14. Dix pays développés sur 31 interviennent pour maintenir à son niveau actuel,

Tableau 1: Perceptions et politiques gouvernementales concernant les niveaux actuels de la fécondité et désir d'intervention en vue de les modifier par commission économique, région et niveau de développement, juillet 1980 a/

Commissions Régionales, Régions Géographiques et niveau de développement		Perceptions gouvernementales concernant l'acceptabilité du taux actuel de fécondité et desir d'intervention en vue de le modifier						Total
		Taux non satisfaisants parce que trop bas: taux plus élevés souhaitables		Taux satisfaisants		Taux non satisfaisants parce que trop élevés: taux plus bas souhaitables		
		Intervention pour augmenter les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Mais mesures d'encouragement ou de dissuasion mises en oeuvre pour maintenir les taux	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention pour diminuer les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	
		I	II	III	IV	V	VI	
CEA Région:	Eastern Africa	-	-	1	6	5	4	16
	Middle Africa	1	2	-	5	1	-	9
	Northern Africa	1	-	-	1	1	3	6
	Southern Africa	-	-	-	-	-	4	4
	Western Africa	1	-	7	4	3	1	16
	Total	3	2	8	16	10	12	51
CEE Région:	Eastern Europe	2	-	3	1	-	-	6
	Northern Europe	-	-	2	5	-	-	7
	Southern Europe	1	-	1	7	-	-	9
	Western Europe	4	1	1	3	-	-	9
	Cyprus, Israel, Turkey	1	1	-	-	-	1	3
	Northern America	-	-	-	2	-	-	2
	USSR	-	-	3	-	-	-	3
	Total	8	2	10	18	-	1	39
CEPAL Région:	Caribbean	-	-	-	1	4	6	11
	Middle America	-	-	1	1	2	3	7
	Temperate S. America	2	1	-	-	-	-	3
	Tropical S. America	1	-	1	7	-	-	9
	Total	3	1	2	9	6	9	30

		I	II	III	IV	V	VI	Total
CEAO Région:	Western S. Asia	1	-	5	4	2	-	12
	Total	1	-	5	4	2	-	12
CESAP Région:	China	-	-	-	-	-	1	1
	Japan	-	-	-	1	-	-	1
	Other East Asia	-	-	2	-	-	1	3
	Eastern S. Asia	2	-	2	1	-	4	9
	Middle S. Asia	-	-	-	2	1	6	9
	Australia and New Zealand	-	-	-	2	-	-	2
	Melanesia	-	-	-	-	1	1	2
	Micronesia-Polynesia	-	-	2	-	1	3	6
	Total	2	-	6	6	3	16	33
	Pays développés	7	1	10	21	-	-	39
	Pays en développement	10	4	21	32	21	38	126
	Total	17	5	31	53	21	38	165

a/ Les noms des pays apparaissent dans le tableau annexe A.XIX.I.

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

un taux jugé satisfaisant et 21 pays en développement sur 53. Aucun pays développé n'estime le taux trop élevé, mais 38 pays en développement sur 59 interviennent pour le diminuer. Si, peu de pays ont modifié leurs perceptions durant cette période 1978-1980, nombreux sont par contre, ceux qui ont décidé d'intervenir pour maintenir ou modifier le niveau de leur fécondité. Nous reviendrons sur ces changements lorsque nous analyserons la situation des pays par niveau de développement.

A. PAYS DEVELOPPES

(Pays de la CEE, moins Israël, Chypre et la Turquie, mais plus le Japon, l'Australie et la Nouvelle Zélande.)

Aucun pays développé n'a changé sa perception à l'égard de la fécondité depuis 1978 (cf tableau 2). Sept pays sur 39 considèrent toujours trop bas le niveau et les tendances du taux de fécondité 1/: il s'agit de 2 pays de l'Europe de l'Est, Bulgarie et République démocratique allemande, 1 pays de l'Europe du Sud, Grèce, et 5 pays de l'Europe occidentale, France, Liechtenstein, Luxembourg, Monaco et République fédérale d'Allemagne. A l'exception de ce dernier pays, tous désirent intervenir pour augmenter leur taux et un ensemble de mesures a été mis en oeuvre pour atteindre cet objectif. En 1980 comme en 1978, aucun pays développé ne perçoit le niveau de la fécondité trop élevé et 31 pays, soit 80 p. 100 des pays développés, sont satisfaits du niveau actuel. Cependant parmi ceux-ci, 10 ont pris des mesures pour maintenir ce niveau. Dans ce groupe de 10 pays, on retrouve une majorité de pays de l'Europe de l'Est: Hongrie, Roumanie, Tchécoslovaquie, URSS, RSS d'Ukraine et RSS de Biélorussie auxquels s'ajoutent Finlande, Irlande, Albanie et Belgique.

Au total donc, 17 pays développés sur 39 (44 p. 100 des pays) mettent en oeuvre des politiques destinées à modifier ou à maintenir le niveau de la fécondité. Comme nous l'avons déjà mentionné, ces politiques peuvent avoir comme finalité première d'une part, une action sur le taux d'accroissement naturel jugé non satisfaisant et, d'autre part, viser en priorité le bien-être des individus et des familles. Elles peuvent aussi, et c'est sans doute l'objectif que poursuivent la plupart des pays développés, essayer de concilier ces deux objectifs simultanément. Mais il n'est pas toujours aisé de discerner dans la pratique lequel de ces objectifs reçoit des gouvernements une attention privilégiée. Cependant si on considère les pays qui interviennent pour augmenter le niveau de leur fécondité, on s'aperçoit que 6 d'entre eux (la Grèce faisant exception) ont en même temps des politiques d'intervention globale pour augmenter leur taux d'accroissement naturel: leurs actions sur la fécondité visent donc principalement une augmentation du taux d'accroissement naturel. Quant aux 10 pays qui mettent en oeuvre des politiques en vue de maintenir la fécondité au niveau actuel, tous ont également une politique de soutien partiel en vue d'accroître le taux d'accroissement naturel (RSS de Biélorussie, RSS d'Ukraine, URSS) ou de le maintenir au niveau actuel (les 7 autres pays). Les politiques de ces pays semblent donc viser simultanément le bien-être des individus et une action sur le taux d'accroissement sans que l'un ou l'autre de ces objectifs ne prédomine apparemment. Si dans l'ensemble, les perceptions et les politiques adoptées à l'égard de la fécondité coïncident avec celles adoptées à l'égard de l'accroissement naturel, elles peuvent cependant en diverger, dans la mesure où la perception d'un niveau d'accroissement naturel résulte d'un processus dans lequel interviennent plusieurs composantes démographiques sur lesquelles peuvent porter

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1/ En 1978, l'Argentine et l'Uruguay se trouvaient dans ce groupe, ils sont maintenant classés parmi les pays en développement.

Tableau 2. Changements dans les perceptions gouvernementales concernant le taux global de fécondité, juillet 1978 - juillet 1980

Pays situés dans la Région de la CEE

	Perceptions gouvernementales concernant l'acceptabilité du taux actuel de fécondité et désir d'intervention en vue de le modifier						
	Taux non satisfaisants parce que trop bas: taux plus élevés souhaitables		Taux satisfaisants		Taux non satisfaisants parce que trop élevés: taux plus bas souhaitables		
	Intervention pour augmenter les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Mais mesures d'encouragement ou de dissuasion mises en oeuvre pour maintenir les taux	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention pour diminuer les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Total
	I	II	III	IV	V	VI	
Nombre de pays dans chaque catégorie en 1978	8	2	11	17	-	1	39
Changements dans les perceptions concernant l'acceptabilité du taux actuel et désir d'intervention en vue de le modifier durant la période 1978 - 1980	b	b	-Pologne -Tchecoslovaquie	-Belgique	b	b	
	b	b	+Belgique	+Pologne +Tchecoslovaquie	b	b	
Nombre de pays dans chaque catégorie en 1980	8	2	10	18	-	1	39

b) Pas de changement
(+) Pays entrant dans cette catégorie
(-) Pays changeant de catégorie

Source: Informations rassemblées à partir des données de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population.

des interventions comme celles sur les migrations internationales (par exemple en Grèce).

Examinons maintenant les mesures d'intervention que les gouvernements des pays développés mettent en oeuvre et qui ont une influence sur le niveau de la fécondité et le bien-être des individus et des familles. On peut regrouper ces interventions en trois grandes catégories: des mesures légales destinées à permettre aux couples d'exercer leur droit de procréer, des mesures économiques destinées à compenser les charges familiales ou à favoriser, par des avantages gradués, l'apparition de comportements procréateurs désirables, et enfin des mesures qui permettent de résoudre les contradictions inhérentes au développement de l'activité professionnelle des femmes et à la maternité[2/].

1. Mesures légales

Les dispositions légales concernant l'accès à la contraception (cf tableau 3) ont évolué, dans la grande majorité des cas, dans le sens de la libéralisation et cela indépendamment des objectifs démographiques visés par les gouvernements. Dans 33 pays sur 39, l'accès aux méthodes modernes de contraception est autorisé et directement (25 pays) ou indirectement (8 pays) soutenu par le gouvernement. L'accès reste autorisé, mais non soutenu par les gouvernements, en Irlande, Saint-Marin, Liechtenstein et Grèce, tandis que les gouvernements de Malte et Saint-Siège continuent à en interdire l'accès. Depuis 1978, l'Irlande, l'Espagne et la Grèce ont pris des dispositions légales en vue de libéraliser l'accès à la contraception: l'Irlande l'autorise maintenant, mais sans soutien gouvernemental (vente de contraceptifs en pharmacie sur présentation d'une ordonnance médicale) ainsi que la Grèce (vente libre de contraceptifs), tandis que le Gouvernement espagnol apporte maintenant un soutien indirect à la diffusion de la contraception. Seuls parmi les pays qui mettent en oeuvre des politiques en vue d'augmenter ou de maintenir le niveau de la fécondité, les Gouvernements de Grèce et Liechtenstein autorisent la diffusion de la contraception, mais n'y apportent aucun soutien.

Le tableau 4 fournit des informations sur les indications légales pour lesquelles l'avortement est autorisé: 13 pays sur les 34, pour lesquels des informations sont disponibles, autorisent l'avortement "à la demande", 16 pays l'autorisent pour des raisons socio-économiques et 28 pour des motifs médicaux entendus au sens large. La totalité des pays autorisent l'avortement, lorsque la vie de la mère est en danger, 23, quand un risque de naissance anormale existe et 18, pour des raisons juridiques (inceste, viol, etc.). Dans 10 pays, l'avortement est également autorisé pour diverses raisons, en particulier pour des raisons liées à l'âge de la femme (femme trop jeune ou trop âgée).

2/ C. Alison McIntosh, "Population Policy in the Liberal Democracies". A Comparative Study of France, Sweden and West Germany. Unpublished Phd. Dissertation, Centre for Population Planning, University of Michigan, 1980.

Tableau 3. Politiques gouvernementales concernant l'accès aux méthodes modernes de régulation des naissances, juillet 1980 a/

Commissions Régionales, Régions Géographiques et niveau de développement		Accès limité	Accès autorisé			Nombre de pays
			non soutenu par gouvernement	Indirectement soutenu par gouvernement	Directement soutenu par gouvernement	
CEA Région:	Eastern Africa	1	3	3	9	16
	Middle Africa	3	2	2	2	9
	Northern Africa	1	-	-	5	6
	Southern Africa	-	-	-	4	4
	Western Africa	-	6	5	5	16
	Total	5	11	10	25	51
CEE Région:	Eastern Europe	-	-	-	6	6
	Northern Europe	- 1/	1	-	6	7
	Southern Europe	3	1	2	3	9
	Western Europe	-	1	5	3	9
	Cyprus, Israel, Turkey	-	1	-	2	3
	North America	-	-	-	2	2
	USSR	-	-	-	3	3
	Total	3	4	7	25	39
CEPAL Région:	Caribbean	-	-	1	10	11
	Middle America	-	-	-	7	7
	Temperate S. America	1	1	-	1	3
	Tropical S. America	-	3	-	6	9
	Total	1	4	1	24	30
CEAO Région:	Western S. Asia (part)	1	5	2	4	12
	Total	1	5	2	4	12

ESAP Région:	China	-	-	-	1	1
	Japan	-	-	-	1	1
	Other East Asia	-	-	-	3	3
	Eastern S. Asia	2	1	-	6	9
	Middle S. Asia	-	1	-	8	9
	Australia and New Zealand	-	-	1	1	2
	Melanesia	-	-	-	2	2
	Micronesia-Polynesia	-	-	-	6	6
	Total	2	2	1	28	33
Pays développés		3	3	8	25	39
Pays en développement		9	23	13	81	126
	Total	12	26	21	106	165

a/ Les noms des pays apparaissent dans le tableau annexe A.XIX.2.

1/ La Grèce a modifié sa politique durant la période 1978-1980 et est classée maintenant dans la catégorie "Accès autorisé, non soutenu par gouvernement".

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

Peu de changements sont intervenus dans les législations concernant l'avortement depuis 1978: la France a définitivement ratifié la loi qui était en vigueur depuis 1975 pour une période d'essai de 5 ans, tandis que Grèce (partiellement), Yougoslavie (Croatie), Italie et Luxembourg (ces deux derniers pays dans le cadre d'une loi d'ensemble concernant la contraception) libéralisaient la législation. Cependant, deux pays de l'Europe septentrionale (Finlande et Norvège) ont apporté quelques restrictions à la loi en vigueur, en réduisant le délai pendant lequel l'avortement "à la demande" est autorisé.

En Europe, les lois sur l'avortement sont relativement libérales mais la situation, loin d'être homogène, oblige à considérer chacune des sous-régions indépendamment.

Dans les pays de l'Europe de l'Est, 3 pays autorisent l'avortement "à la demande" (Bulgarie, République populaire allemande et Hongrie) et 5, pour des raisons socio-économiques (les 3 mêmes pays plus Tchécoslovaquie et Pologne) tandis qu'en Roumanie, l'avortement n'est plus autorisé pour ces raisons. Cependant une révision des dispositions légales limite en fait considérablement l'accès à l'avortement en Bulgarie (loi de 1974), Tchécoslovaquie (loi de 1973), Hongrie (loi de 1973) et Pologne (1969).

En Bulgarie, l'avortement est autorisé "à la demande", si la femme a au moins un enfant vivant, ou pour des raisons socio-économiques telles que: si elle est veuve, divorcée ou séparée, ou si elle a un enfant vivant et est âgée de plus de 40 ans. En Tchécoslovaquie, l'avortement n'est pas accordé "à la demande", mais seulement dans certaines situations socio-économiques jugées difficiles: femme âgée de plus de 40 ans, femme ayant trois enfants vivants ou plus, femme célibataire, séparée, divorcée ou veuve, ou en mauvais état de santé ou encore si ses conditions de logement ou de revenus sont insuffisantes.

En Hongrie, l'avortement est accordé "à la demande" cependant un comité doit donner au préalable son autorisation, qui est automatique, si la femme est célibataire, séparée ou divorcée, veuve, âgée de plus de 40 ans ou si elle a au moins trois enfants. L'avortement est également accordé pour des raisons considérées d'ordre socio-économique, si la grossesse résulte d'un échec des moyens contraceptifs intra-utérin ou si la femme a deux enfants et a subi précédemment une intervention obstétricale.

En Pologne, l'avortement est autorisé pour des raisons d'ordre socio-économique telles que des conditions de vie difficiles, qu'aggraverait encore la naissance d'un nouvel enfant.

En Roumanie, l'avortement n'est permis ni "à la demande" ni pour raisons socio-économiques; cependant, la femme âgée de plus de 45 ans ou ayant quatre enfants à charge peut obtenir l'autorisation d'avorter. En Allemagne de l'Est où la loi est plus libérale, l'avortement est autorisé "à la demande" et pour des raisons économiques.

Tableau 4. Indications légales pour lesquelles l'avortement est autorisé: Répartition des pays par commission régionale, par niveau de développement et par indication légale de l'avortement a/ (Nombre de pays)

Commissions Régionales, Régions Géographiques et niveau de developpement		Indications pour lesquelles l'avortement est autorisé:									
		A la demande	Socio-économiques	Risque à la santé de la mère au sens large	Vie de la mère en danger	Risque de naissance anormale	Juridiques	Autres	Nombre de pays avec information	Nombre de pays sans information	Total
CEA Région:	Eastern Africa	-	1	5	14	2	3	1	14	2	16
	Middle Africa	-	1	2	7	-	1	-	7	2	9
	Northern Africa	1	-	3	6	2	-	-	6	-	6
	Southern Africa	-	-	3	4	1	1	-	4	-	4
	Western Africa	-	-	6	14	1	1	2	14	2	16
	Total	1	2	19	45	6	6	3	45	6	51
CEE Région:	Eastern Europe	3	5	6	6	6	6	4	6	-	6
	Northern Europe	3	6	6	7	6	5	3	7	-	7
	Southern Europe	2	1	4	7	3	1	1	7	2	9
	Western Europe	2	2	6	8	4	3	1	8	1	9
	Cyprus, Israel, Turkey	-	1	2	3	3	3	1	3	-	3
	North America	1	-	2	2	-	-	-	2	-	2
	USSR	1	-	1	1	1	-	-	1	2	3
	Total	12	15	27	34	23	18	10	34	5	39
CEPA Région:	Caribbean	1	1	7	10	1	-	-	11	-	11
	Middle America	-	-	2	7	1	2	-	7	-	7
	Temperate S. America	-	1	1	3	-	2	-	3	-	3
	Tropical S. America	-	-	3	8	-	4	-	8	1	9
	Total	1	2	13	28	2	8	-	29	1	30
CEAO Région:	Western S. Asia (part)	-	-	1	8	-	-	-	8	4	12
	Total	-	-	1	8	-	-	-	8	4	12

CESAP Region:	China	1	-	-	-	-	-	-	1	-	1
	Japan	-	1	1	1	1	1	-	1	-	1
	Other East Asia	-	1	3	3	2	2	-	3	-	3
	Eastern S. Asia	1	-	2	7	1	2	-	7	2	9
	Middle S. Asia	1	1	3	7	2	1	-	7	2	9
	Australia and New Zealand	1	1	2	2	2	2	1	2	-	2
	Melanesia	-	-	1	2	-	-	-	2	-	2
	Micronesia-Polynesia	-	1	2	3	1	1	-	3	1	6
	Total	4	5	14	27	9	9	1	28	5	33
Pays développés		13	16	28	34	23	18	10	34	5	39
Pays en développement		5	8	46	108	17	23	4	110	16	126
	Total	18	24	74	142	40	41	14	144	21	165

a/ Les noms des pays apparaissent dans le tableau annexe A.XIX.3.

Sources: 1. Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

2. United Nations Fund for Population Activities 1979, Survey of Laws on Fertility Control.

3. World Health Organization, Geneva, 1979, International Digest of Health Legislation, Vol.30, NO.3

En Europe du Nord, l'avortement est autorisé "à la demande", au Danemark, Norvège et Suède et, pour raisons socio-économiques largement interprétées, en Finlande, Royaume-Uni et Islande (conditions un peu plus strictes). L'Irlande est le seul pays de la région à avoir une loi très stricte, n'autorisant l'avortement que si la vie de la mère est en danger. Cependant en 1978, la Finlande et la Norvège ont réduit la durée de la grossesse durant laquelle l'avortement "à la demande" est autorisé: ce délai a été ramené à 12 semaines.

En Europe du Sud, les législations sont nettement plus restrictives; seules l'Italie (loi de 1977 et 1978) et Yougoslavie accordent l'avortement "à la demande". En Grèce, bien que la loi reste encore assez restrictive, l'avortement est maintenant autorisé pour raisons de risque à la santé mentale de la mère (amendement de 1978).

En Europe de l'Ouest, 2 pays, l'Autriche (loi de 1974) et la France (loi de 1979) autorisent l'avortement "à la demande", la République Fédérale d'Allemagne et le Luxembourg (1978) pour raisons socio-économiques. Mais en Autriche, si la loi autorise l'avortement "à la demande", il semble que dans les faits, la réticence de nombreux médecins et d'organisations hospitalières le rende d'accès difficile. Par contre en Belgique (loi de 1867) et Pays-Bas (loi de 1881), où les anciennes législations très restrictives n'ont pas été amendées, les pénalités prévues par la loi ne sont pas appliquées et l'avortement est en pratique largement répandu, particulièrement aux Pays-Bas où de nombreuses cliniques (spécialisées et sans but lucratif) opèrent à travers le pays. Enfin aux Etats-Unis, bien que la législation varie d'un état à l'autre, l'avortement est largement accordé "à la demande". Il est également accordé à la demande en URSS mais l'Etat ne l'encourage pas.

Comme nous l'avons vu, nombre de pays européens autorisent l'avortement "à la simple demande" ou pour des raisons d'ordre socio-économique, cependant leurs législations prévoient un certain nombre de modalités d'applications qui en rendent parfois l'accès moins aisé.

A l'exception des Etats-Unis où un avortement est autorisé jusqu'à la fin du deuxième trimestre de grossesse,3/ partout ailleurs les durées de grossesse durant lesquelles l'avortement est autorisé sont beaucoup plus courtes: 12 semaines en général. La Bulgarie, Yougoslavie et France imposent même 10 semaines, alors que la Suède le permet jusqu'à 18 semaines. D'autre part, un certain nombre de pays n'accordent l'autorisation d'avorter que sur avis d'un comité médical ou après consultation auprès d'un centre de santé ou de bien-être (pays de l'Europe de l'Est, Italie, France). En outre, dans ces deux derniers pays, une période d'attente et de réflexion est imposée à partir de la demande initiale d'avortement.

Les systèmes d'assurance-santé ou de sécurité sociale couvrent en général les frais des avortements légalement autorisés, encore que l'on trouve des différences d'un pays à l'autre. En République démocratique allemande par exemple, l'avortement est considéré au même titre que toute

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3/ Durant le deuxième trimestre, certains états peuvent avoir des dispositions légales particulières règlementant l'avortement en vue de préserver la santé de la mère.

autre maladie: il est donc remboursé par l'assurance-santé et des congés maladie sont octroyés. En Tchécoslovaquie par contre, les frais de l'avortement sont à la charge de l'assurée alors que l'ensemble des actes médicaux sont gratuits. L'avortement est gratuit en Suède, Royaume-Uni, Yougoslavie. Les tarifs sont déterminés par la loi, en Hongrie et Danemark. En France, les frais occasionnés par un avortement thérapeutique sont couverts par la Sécurité Sociale.

Le tableau 5 fournit des informations sur le nombre absolu d'avortements et sur le taux d'avortement (rapporté à la population totale et aux femmes en âge fécond), pour quelques pays. Les années choisies pour l'information tiennent compte dans la mesure du possible des mises en vigueur de nouvelles législations (France) ou d'amendement aux législations déjà existantes (certains pays de l'Europe de l'est).

En général, les statistiques que l'on possède sur l'avortement sont relativement incomplètes: d'une part, parce que pendant trop longtemps et dans trop de pays l'avortement a été pratiqué illégalement par du personnel médical et surtout non médical, et que d'autre part, à l'heure actuelle, les pays où l'avortement est légalisé n'enregistrent souvent que les avortements opérés dans les hôpitaux publics ou gouvernemantaux. Ce n'est que depuis quelques années seulement que certains pays enregistrent les avortements pratiqués dans les institutions privées, mais les opérations d'interruption de grossesse, pratiquées par les médecins en cabinet privé, restent souvent omises à moins que la loi ne les y oblige et ne les contrôle strictement.

Dans les pays de l'Europe de l'Est, l'avortement a été très largement pratiqué comme méthode de régulation des naissances: taux d'avortement de 252 p. 1000 femmes en 1965 en Roumanie par exemple. Mais l'amendement de la loi dans plusieurs pays a fait diminuer les taux de façon très importante. L'exemple le plus frappant est celui de la Roumanie où les taux sont passés de 252 p. 1000 en 1965 à 46 p. 1000 en 1967 pour remonter ensuite jusqu'à 81 p. 1000 en 1973. Il semble donc que le gouvernement ait appliqué la loi de façon très stricte dans un premier temps, et se soit montré plus libéral dans la suite. Les taux sont partout en décroissance dans les pays de l'Europe de l'Est mais restent cependant à un niveau nettement plus élevé que dans les autres pays de la CEE.

Dans les pays d'Europe du Nord, on assiste entre 1970 et 1976-1977 à une lente progression des taux, suivie dans les dernières années, par un arrêt de la progression et même une diminution (exemple du Danemark, Finlande, Norvège ou Suède).

Dans les autres pays d'Europe présentés dans le tableau 5, les taux restent peu élevés, mais il faut sans doute tenir compte des restrictions que nous avons faites à propos de l'enregistrement des avortements.

Le taux est en progression au Canada et aux Etats-Unis et se situe dans ce dernier pays, plus au moins au niveau de celui des pays de l'Europe de l'Est.

Tableau 5. Nombre d'avortements légaux et taux d'avortement dans quelques pays développés

Région, pays et année		Nombre d'avortements	Taux d'avortement (p 1000) Population totale	Femmes 15-44 ans
Europe orientale				
Bulgarie	1970	120,900	14.2	64.0
	1971	132,500	15.5	70.2
	1972	133,600	15.6	70.9
	1973	115,400	13.4	61.2
	1974	125,000	14.4	66.4
	1975	123,700	14.2	65.8
	1976	121,100	13.8	64.5
Tchécoslovaquie	1970	99,800	6.9	32.3
	1971	97,300	6.8	31.4
	1972	91,300	6.3	29.2
	1973	81,200	5.6	25.9
	1974	83,100	5.7	26.4
	1975	81,700	5.5	25.9
	1976	84,600	5.7	26.8
	1977	89,000	-	-
République démocratique allemande	1973	110,800	6.5	32.2
	1974	99,700	5.9	28.8
	1975	87,800	5.2	25.2
	1976	81,900	4.9	23.3
Hongrie	1970	192,300	18.6	83.5
	1971	187,400	18.1	81.1
	1972	179,000	17.2	77.5
	1973	169,600	16.3	73.5
	1974	102,000	9.7	44.3
	1975	96,200	9.1	41.9
	1976	94,700	8.9	41.5
	1977	89,100	8.4	39.2
Pologne	1969	212,933	-	-
	1970	214,034	-	-
	1971	203,619	-	-
	1972	204,562	-	-
	1973	210,682	-	-
	1974	214,387	-	-
	1975	212,101	-	-
	1976	215,368	-	-
	1977	213,911	-	-

Région, pays et année		Nombre d'avortements	Taux d'avortement (p 1000) Population totale	Femmes 15-44 ans
Roumanie	1965	1,115,000	58.6	252.3
	1966	973,000	50.5	218.7
	1967	206,000	10.6	46.0
	1968	220,000	11.1	48.0
	1969	258,000	12.9	56.9
	1970	292,000	14.4	63.9
	1971	330,000	16.2	71.9
	1972	381,000	18.5	82.7
	1973	376,000	18.1	81.3
Europe septentrionale				
Danemark	1970	9,400	1.9	9.4
	1971	11,200	2.2	11.1
	1972	13,000	2.6	12.9
	1973	16,500	3.3	16.2
	1974	24,900	4.9	24.2
	1975	27,900	5.5	27.0
	1976	26,800	5.3	25.8
	1977	25,700	5.0	24.4
Finlande	1970	14,800	3.2	13.8
	1971	20,400	4.4	18.9
	1972	22,200	4.8	20.4
	1973	23,400	5.0	22.4
	1974	22,800	4.9	21.8
	1975	21,500	4.6	20.4
	1976	19,800	4.2	18.6
Norvège	1970	7,900	2.0	10.9
	1971	10,400	2.7	14.1
	1972	12,200	3.1	16.4
	1973	13,700	3.5	18.2
	1974	15,200	3.8	20.0
	1975	15,100	3.8	19.7
	1976	14,800	3.7	19.0
	1977	15,500	3.8	19.7
Suède	1970	16,100	2.0	10.2
	1971	19,300	2.4	12.2
	1972	24,200	3.0	15.2
	1973	26,000	3.2	16.3
	1974	30,600	3.8	19.2
	1975	32,500	4.0	20.2
	1976	32,400	3.9	20.0
	1977	31,200	3.8	19.2

Région, pays et année		Nombre d'avortements	Taux d'avortement (p 1000) Population totale	Femmes 15-44 ans
Royaume-Uni*	1968	24,900	-	-
	1969	58,200	-	-
	1970	86,600	-	-
	1971	133,000	-	-
	1972	167,500	-	-
	1973	174,600	-	-
	1974	170,400	-	-
	1975	147,000	-	-
	1976	135,900	-	-
	1977	140,700	-	-
Europe occidentale				
France	1976	133,416	-	-
	1977	150,149	-	-
	1978	150,246	-	-
République fédérale d'Allemagne	1970	4,900	0.08	0.4
	1971	6,900	0.11	0.6
	1972	8,600	0.14	0.7
	1973	13,000	0.21	1.1
	1974	17,200	0.28	1.4
	1975	21,200	0.34	1.7
	1976			
	1977	54,300	0.88	4.1
Pays-Bas	1970	10,000	0.8	3.7
	1971	15,000	1.1	5.5
	1972	21,000	1.6	7.6
	1973	20,000	1.5	7.1
	1974	17,000	1.3	6.0
	1975	16,000	1.2	5.5
	1976	16,000	1.2	5.5
Amérique du Nord				
Canada	1970	11,200	0.5	2.6
	1971	30,900	1.4	6.6
	1972	38,900	1.8	8.2
	1973	43,100	2.0	8.8
	1974	48,200	2.1	9.5
	1975	49,300	2.2	9.5
	1976	54,500	2.4	10.3
	1977	57,600	2.5	10.6
Etats-Unis	1973	744,600	3.5	16.6
	1974	898,600	4.2	19.6
	1975	1,034,200	4.8	22.1
	1976	1,179,300	5.5	24.5
	1977	1,270,000	5.9	25.8

* L'Irlande du Nord n'est pas comprise

Annuaire Démographique 1977, vingt-neuvième édition, Département des affaires économiques et sociales internationales, Nations Unies, New York 1978.

Annuaire Démographique 1978, trentième édition, op. cit.

Christopher Tietze, Induced Abortion : 1979, Third Edition, New York 1979, a Population Council Fact Book, The Population Council, New York.

Pour la France, neuvième support sur la situation démographique de la France, Population No 4-5, Juillet 1980, Revue bimestrielle de l'Institut national d'études démographiques.

Nombre de pays développés n'ont pas encore légiféré en matière de stérilisation, bien que le Comité des Ministres du Conseil de l'Europe ait recommandé en 1975, que les gouvernements prennent les mesures législatives nécessaires en vue de libéraliser la stérilisation et de la considérer comme moyen de régulation des naissances. On note dans le tableau 6 que 5 pays sur les 34, pour lesquels des informations sont disponibles, considèrent la stérilisation illégale. Parmi les 29 autres pays, 16 l'autorisent "à la demande", 2 pour des raisons socio-économiques, 2 comme moyen de régulation des naissances, 9 pour des raisons médicales et 5 pour des raisons de malformation héréditaires.

C'est principalement dans les pays d'Europe du Nord que la stérilisation volontaire a été libéralisée par des lois récentes (à l'exception de l'Irlande). Au Danemark (loi de 1973), la stérilisation est autorisée "à la demande" dès l'âge de 25 ans, sans autres conditions (le consentement du conjoint n'est même pas nécessaire); en dessous de cet âge les conditions sont toutefois plus strictes. Les dispositions légales sont à peu près identiques en Islande (loi de 1975), Norvège (loi de 1977), et Suède (loi de 1975); la Finlande est plus restrictive et n'autorise la stérilisation que pour des raisons d'ordre socio-économique, médical, et pour risque de malformations héréditaires et autres, et dans le cas où une grossesse ne peut être évitée par d'autres moyens contraceptifs. C'est cependant au Royaume-Uni que la loi est la plus orientée vers la régulation des naissances, la stérilisation étant considérée comme un excellent moyen contraceptif: la stérilisation est accordée sans limite d'âge pour raison contraceptive et pratiquée gratuitement par le Service National de Santé. En Europe du Sud, seules l'Italie (loi de 1978) et Yougoslavie (1977-1978) autorisent la stérilisation "à la demande" mais la personne doit être âgée d'au moins 35 ans en Yougoslavie.

En Europe de l'Ouest la situation légale de la stérilisation volontaire n'est pas très clairement définie, mais il semble qu'un certain laxisme l'autorise dans la pratique. En Autriche, la stérilisation "à la demande" est légale mais, comme pour l'avortement, rencontre l'opposition de nombreux médecins ou hôpitaux. Elle est autorisée également "à la demande" en Belgique, France (après entente avec le médecin), Pays-Bas et Suisse. La République fédérale d'Allemagne l'autorise pour des raisons sociales sérieuses.

En Europe de l'Est, la stérilisation volontaire est légale en Tchécoslovaquie, Pologne et Bulgarie, mais avec certaines restrictions: personnes d'"un certain âge" en Bulgarie, femme âgée de 35 ans et ayant au moins 3 enfants en Tchécoslovaquie. Mais la stérilisation n'est pas encouragée dans les pays de l'Est et est par conséquent peu pratiquée.

La stérilisation est autorisée "à la demande" au Canada (matière à discuter avec le médecin) et autorisée sans aucune restriction aux Etats-Unis, si la personne est âgée de 18 ou 21 ans selon les Etats.

La stérilisation n'est pas légale en URSS et n'est donc pas utilisée comme méthode de régulation des naissances.

Durant les récentes années, le nombre de couples utilisant la stérilisation volontaire comme moyen contraceptif s'est accru considérablement dans les pays développés: on estime le nombre de couples stérilisés à 12 millions aux Etats-Unis (3 millions en 1970), 10 millions en Europe (3 millions en 1970), et 1 million au Canada (0,5 million en 1970).

Les stérilisations pratiquées dans les pays développés représentent ainsi quelque 25 p. 100 des stérilisations pratiquées dans le monde (63 p. 100 du total sont pratiquées en Chine et en Inde seulement). En 1970 la proportion était plus élevée (32 p. 100) mais la Chine, en particulier, n'avait pas encore commencé la mise en oeuvre de sa vaste campagne de stérilisation, dont nous reparlerons dans la suite.4/

2. Mesures d'incitation

Un deuxième type de mesures que prennent les gouvernements en vue de modifier les niveaux de fécondité ou d'assurer le bien-être individuel est constitué par les avantages d'ordre économique que l'Etat attribue aux familles. Ces avantages représentent en fait une prise en charge plus ou moins importante des coûts occasionnés par la venue d'un enfant et son élevage. Elles remplissent une double fonction, qu'il n'est pas toujours facile de distinguer: une fonction sociale de protection du revenu des familles dans tous les pays étudiés, et une autre fonction de stimulant démographique dans les pays à politique pronataliste.

Ces mesures économiques se présentent sous forme d'avantage directs et d'avantages indirects. Les avantages directs sont d'ordre financier et peuvent être constitués, soit par un système d'abattement d'impôts sur le revenu, soit par un système de prestations familiales, les deux systèmes pouvant exister conjointement.5/ Dans le premier cas, le système repose sur le principe que la part du revenu consacrée à l'élevage de l'enfant ne doit pas être taxée; par conséquent un montant forfaitaire ou un montant progressif, au prorata du nombre d'enfants à charge, est déduit du revenu

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4/ C.P. Green, Sterilisation volontaire: principale méthode mondiale de contraception. Population Reports; spécial, No 2, janvier 1979, Population Information Program, The John Hopkins University.

R.T. Ravenholt, Future prospects for voluntary sterilization, in ME Schima and I. Lubell (editions) : Voluntary Sterilization : a Decade of Achievement, Proceedings of the 4th International Conference om Voluntary Sterilization, Seoul, Korea, May 7-10, 1979.

5/ Pour le cas de la France, voir par exemple Gérard Calot, Niveau de vie et nombre d'enfants: un bilan de la législation familiale et fiscale française de 1978, Population No 1, janvier-février 1980, Editions de l'Institut national d'études démographiques.

Tableau 6. Indications légales pour lesquelles la stérilisation est autorisée: Répartition des pays par commission régionale, par niveau de développement et par indications légales de la stérilisation a/

(Nombre de pays) a/

Commissions Régionales, régions Géographiques et niveau de développement		Indications pour lesquelles la stérilisation est autorisée:					Statut juridique			
		A la demande	Socio-économiques	Régulation des naissances	Médicales	Malformations héréditaires et autres	Illégale	Légale ou non clairement définie	Nombre de pays sans information	Total
CEA Région:	Eastern Africa	2	1	-	5	-	5	7	4	16
	Middle Africa	-	-	-	-	-	6	1	2	9
	Northern Africa	2	-	1	2	2	3	2	1	6
	Southern Africa	2	-	2	1	-	-	4	-	4
	Western Africa	1	-	-	1	-	4	10	2	16
	Total	7	1	5	7	2	18	24	9	51
CEE Région:	Eastern Europe	2	-	-	3	1	1	5	-	6
	Northern Europe	4	1	2	1	1	-	7	-	7
	Southern Europe	2	-	-	2	-	4	3	2	9
	Western Europe	3	1	-	1	1	-	8	1	9
	Cyprus, Israel, Turkey	-	-	-	2	1	3	-	-	3
	North America	2	-	-	-	-	-	2	-	2
	USSR	-	-	-	1	-	-	1	2	3
	Total	15	2	2	10	3	8	26	5	39
CEPAL Région:	Caribbean	3	-	-	1	1	1	6	4	11
	Middle America	3	1	-	1	1	1	6	-	7
	Temperate S. America	-	-	-	1	-	2	1	-	3
	Tropical S. America	3	-	-	2	2	3	5	1	9
	Total	11	1	-	5	4	7	18	5	30
CEAO Région:	Western S. Asia (part)	1	-	-	2	2	9	2	1	12
	Total	1	-	-	2	2	9	2	1	12
CESAP Région:	China	1	-	-	-	-	-	1	-	1
	Japan	-	-	-	1	1	-	1	-	1
	Other East Asia	-	-	1	-	-	2	1	-	3
	Eastern S.Asia	1	2	2	2	1	1	6	2	9
	Middle S. Asia	5	-	1	-	-	1	6	2	9
	Australia and New Zealand	1	-	-	-	-	-	2	-	2
	Melanesia	-	-	-	-	-	-	1	1	2
	Micronesia -Polynesia	1	-	-	-	-	-	1	5	6
	Total	9	2	4	5	3	4	19	10	33
Pays développés		16	2	2	9	5	5	29	5	39
Pays en développement		27	4	7	21	13	41	60	25	126
	Total	43	6	9	30	18	46	89	30	165

a/ Les noms des pays apparaissent dans le tableau annexe A.XIX.4.

Sources: 1. United Nations Population Policy Inquiries and Population Division, Population Policy Data Bank.
2. United Nations Fund for Population Activities 1979, Survey of Laws on Fertility Control.
3. Jean-Paul Sardon, La stérilisation dans le monde.II. Données statistiques, Population, numéro 3, Mai-Juin, Revue bimestrielle de l'Institut national d'études démographiques.

imposable. Mais ce système en vigueur dans plusieurs pays semble perdre de son importance relative, au profit des prestations familiales.6/ On traitera plus particulièrement dans ce rapport des prestations familiales.

Le système des prestations familiales consiste en versements de sommes d'argent, taxables ou non, durant la grossesse, à la naissance de l'enfant (prime à la naissance), et pour son élevage (allocations familiales mensuelles ou trimestrielles), auxquels s'ajoute, dans certains pays, le versement d'allocations-vacances, d'allocations-rentrée scolaire (pécule-vacances, pécule-rentrée), etc. Des avantages indirects tels que réduction sur les coûts de transport public, allocations logement, etc. sont parfois aussi octroyés. Le montant de ces prestations familiales est en général indépendant du revenu, mais ce n'est pas toujours le cas: au Danemark, par exemple, les familles à revenu élevé ne les perçoivent pas. Dans de nombreux pays, le montant de la prime à la naissance et des allocations familiales est fonction du rang de l'enfant. Dans d'autres, le montant des allocations est modulé selon l'âge de l'enfant, de façon à compenser plus largement les coûts croissants d'élevage et d'éducation.

Le tableau 7 présente, pour les pays membres de l'OECD, des informations sur la part des budgets nationaux consacrée aux dépenses sociales et, en particulier, aux prestations familiales. L'écart entre les différents pays est assez important: l'Australie, Canada, Finlande et Japon surtout, consacrent moins de 1 p. 100 de leur produit intérieur brut aux prestations familiales mais d'autres y consacrent entre 1 et 2 p. 100 et quelques pays comme la Belgique et la France, plus de 2 p. 100. Cependant certains pays donnent la préférence à l'abattement d'impôts sur le revenu plutôt qu'aux prestations familiales, pour compenser le revenu des familles. Le tableau 8 indique la part que représente dans le revenu brut d'un ouvrier de niveau moyen, ayant deux enfants, les prestations familiales et l'ensemble des avantages familiaux, incluant l'abattement d'impôts sur le revenu, en 1972. On constate un écart important entre les différents pays: le Japon, Canada, Etats-Unis, Australie et les pays de l'Europe septentrionale forment un groupe dans lequel la part des avantages familiaux représente environ 5 p. 100 du revenu brut (2,0 p. 100 au Japon, 7,0 en Suède). Par opposition, cette part monte à près de 14 p. 100 en Autriche, 15 p. 100 en Belgique et près de 17 p. 100 en France.

Le tableau 9 présente quelques informations sur les montants des allocations familiales et des suppléments versés en fonction du rang et de l'âge de l'enfant. Les allocations sont allouées, en général, jusqu'à 16 ou 18 ans mais quelques pays en prolongent le versement jusqu'à l'âge de 25 et même de 27 ans, si l'enfant poursuit des études et reste donc à la charge de ses parents. Cependant d'un pays à l'autre le montant des

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6/ Kenneth Messere and Jeffrey Orvens. The treatment of dependent children under income tax and social welfare systems. Document présenté à la réunion du Groupe d'Experts ISSA sur "The relationship between Social Security and Fiscal Systems" Jérusalem (Israël) 12-14 décembre 1978.

Tableau 7: Dépenses publiques consacrées aux programmes sociaux et aux prestations familiales 7/

	Dépenses publiques consacrées aux programmes sociaux en pourcentage du produit intérieur brut 8/	Part relative des dépenses consacrées aux prestations familiales (en p. 100) dans le budget national consacré au bien-être social 8/	Dépenses publiques consacrées aux prestations familiales (en pourcentage du produit intérieur brut 8/
Australie	4,0	14,8	0,59
Autriche	15,3	11,4	1,74
Belgique	14,1	21,9	3,09
Canada	7,3	8,0	0,59
Danemark	9,9	15,5	1,29
Finlande	9,9	7,3	0,65
France	12,4	20,0	2,49
Rép. féd. allemande	12,4	2,7	0,34
Irlande	6,4	12,9	0,90
Italie	10,4	11,2	1,17
Japon	2,8	2,5	0,07
Pays Bas	14,1	15,1	1,85
Nouvelle Zélande	6,5	27,5	1,80
Norvège	9,8	15,6	1,30
Suède	9,3	14,0	1,08
Royaume-Uni	7,7	7,1	0,56
Etats-Unis	8,0	-	-

7/ Public expenditure on income maintenance programmes, OECD, Paris, Studies in resource allocation, July 1976.

8/ Les données comparatives se rapportent à des années différentes pour chaque pays mais se réfèrent toutes à la période 1970-1975.

Tableau 8: Prestations familiales et avantages familiaux totaux pour une famille de deux enfants, 9/ 1972

Pourcentage du revenu brut d'un ouvrier de niveau moyen

	Total des avantages incluant l'abattement d'impôts sur le revenu	dont prestations familiales
Australie	4,3	1,7
Autriche	13,9	9,1
Belgique	15,2	13,6
Canada	3,8	1,8
Danemark	5,5	5,5
Finlande	6,2	3,8
France	16,6	13,8
République fédérale d'Allemagne	4,0	- 10/
Irlande	7,8	1,4
Italie	8,4	7,9
Japon	2,0	-
Pays Bas	8,6	7,3
Nouvelle Zélande	8,2	7,6
Norvège	6,0	6,0
Suède	7,3	7,3
Royaume-Uni	8,5 11/	2,6
Etats-Unis	3,5	-

9/ Public expenditure on income maintenance programmes; op. cit.

10/ Les allocations sont versées seulement aux personnes dont le revenu est inférieur à un certain plafond, qui est dépassé dans l'exemple ci-dessus.

11/ Les allocations familiales étant taxables, le montant total est réduit de 1 p. 100 dans cet exemple.

Tableau 9. Montant des allocations familiales et des suppléments versés en fonction du rang et de l'âge de l'enfant, dans quelques pays européens 12/

Situation au 1er juillet 1978

	Danemark	Irlande	Royaume Uni	Pays Bas
Limite d'âge :				
- normal	16 ans	16 ans	16 ans	16 ans
- prolongée pour raisons d'études	-	18 ans	19 ans	27 ans
- enfant handicapé	-	18 ans	-	18 ans
Montant de l'allocation 13/	chaque enfant:21,35	1er enfant 3,40 2ème enfant 6,10 3ème enfant 7,25	chaque enfant:14,90	1er enfant 19,80 2ème et 3ème 41,40 4ème et 5ème 55,25 6ème et 7ème 61,15 8ème et suivant 67,60
Montant supplémentaire en fonction de l'âge 13/	jusqu'à 16-17 ans maximum:7.700 couronnes par an si le revenu des parents n'exède pas le seuil de 7.000 couronnes	-	-	- en-dessous de 16 ans, montant doublé si l'enfant ne vit pas à la maison pour raisons d'éducation, d'invalidité - entre 16 et 27 ans, montant triplé si l'enfant ne vit pas à la maison pour raisons d'éducation et reste à la charge de ses parents

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Tableau 9 (suite)

	Rép. féd. allemande	Belgique	France	Italie	Luxembourg
Limite d'âge :					
- normal	18 ans	16 ans	16 ans	18 ans	18 ans
- prolongée pour raisons d'études	27 ans	25 ans	20 ans	26 ans	25 ans
- enfant handicapé	pas de limite	pas de limite	20 ans	pas de limite	pas de limite
Montant de l'allocation 2/	1er enfant 19,40 2ème enfant 31,0 3ème enfant 58,15	1er enfant 34,60 2ème enfant 54,90 3ème enfant 75,20 4ème enfant 76,70 5ème enfant 77,25	2ème enfant 34,90 3ème enfant 57,70 4ème enfant 56,15 5ème enfant 53,10	chaque enfant 9,30	1er enfant 28,40 2ème enfant 28,40 3ème enfant 73,20
Montant supplémentaire en fonction de l'âge 2/	-	6-10 ans 263,25 frs belges 10-14 ans 464,25 " 14 ans et plus 751,50 "	à partir du 2ème enfant au-dessus de 10 ans 76,50 frs français au-dessus de 15 ans 136 frs français	-	à partir de 6 ans 115 frs lux. à partir de 12 ans 375 frs lux.

12/ Comparative table of the social security systems in the member states of the European Communities; tenth Edition, Commission of the European Communities. **Situation at 1 July 1978, ed. al.**

13/ Les montants des allocations sont donnés en **Unités de Compte Européen (ECU); taux de conversion :**

1 ECU : 7,02342 couronnes danoises
0,6692 livres anglaises
2,7758 florins hollandais
2,57941 marks allemands
40,6585 francs belges
5,60086 francs français
1.061,48 livres italiennes
40,6585 francs luxembourgeois

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allocations et des augmentations en fonction du rang de l'enfant dans la famille varient: montant modeste au Danemark, Royaume-Uni, Italie, où chaque enfant de la famille reçoit la même somme; montant croissant progressivement jusqu'au 3ème enfant en République fédérale d'Allemagne, Irlande, Luxembourg, jusqu'au 5ème enfant, en France et Belgique et jusqu'au 8ème aux Pays-Bas. La comparaison des montants alloués doit tenir compte à la fois du montant de base (celui alloué au 1er enfant) et de l'échelle de progression selon le rang de l'enfant. Ainsi en Islande, l'allocation versée au 3ème enfant est double de celle versée au 1er, mais le montant reste modeste (de 3,4 à 7,25 ECU). En Belgique, le montant versé au 1er enfant est le plus élevé parmi les pays cités, et il est plus que doublé à partir du 3ème enfant, (de 34,60 ECU pour le 1er à 75,20 pour le troisième); après le 3ème enfant l'augmentation de l'allocation est très faible (76,70 ECU pour le 4ème, 77,25 pour le 5ème). Aux Pays-Bas, les montants et l'augmentation selon le rang de l'enfant dans la famille sont à la fois moins importants, comparés à la Belgique ou au Luxembourg. En France, le montant est progressif jusqu'au 3ème enfant, puis il décroît à partir du 4ème et jusqu'au 5ème. Le montant versé pour le 3ème enfant en Belgique est supérieur à celui versé dans tous les autres pays, pour un enfant de n'importe quel rang.

Un supplément d'allocations familiales est versé selon l'âge de l'enfant dans plusieurs pays: en Belgique l'échelle d'âge comprend 3 groupes, les enfants âgés de 6 à 10 ans, de 10 à 14 ans et de 14 ans et plus. Le montant du supplément pour ces derniers est triple de celui versé aux enfants âgés de 6 à 10 ans. Dans les autres pays, l'échelle d'âge ne comprend que deux groupes: au dessus de 10 and et au dessus de 15 en France; au dessus de 6 ans et de 12 ans au Luxembourg, etc. Aux Pays-Bas, le montant de base de l'allocation peut être doublé ou triplé en fonction de l'âge de l'enfant et sous certaines conditions. D'autres prestations familiales peuvent encore venir s'ajouter à ce système déjà complexe: en Italie, une allocation est versée à la famille, si la mère n'a pas de revenus, et en France, si la famille a un enfant en-dessous de 3 ans ou si la famille compte au moins 3 enfants (complément familial). Certains pays versent encore des prestations aux familles, lors de la entrée scolaire, sous forme d'allocation prénatale, de prime à la naissance (d'un montant décroissant selon le rang en Belgique, fixe au Luxembourg et en France), de prime de vacances (en Belgique), etc. En France récemment, la prime versée à la naissance de l'enfant de rang 3 a été augmentée de façon substantielle en vue d'encourager la naissance d'un troisième enfant dans les familles.

Dans les pays de l'Europe de l'Est, le montant des allocations familiales a toujours été traditionnellement élevé et peut représenter aujourd'hui, selon le nombre d'enfants, une part extrêmement importante du revenu: de 17 pour 100 du revenu mensuel d'un ouvrier ou d'un employé ayant 2 enfants en Hongrie, à 54 pour 100 avec 5 enfants, de 18 pour 100 (2 enfants) à 64 pour 100 (5 enfants) en Tchécoslovaquie (cf tableau 10). On notera que c'est à partir du deuxième et du troisième enfant que les allocations deviennent particulièrement importantes (Bulgarie, Roumanie,

Tableau 10. Part relative des prestations dans le revenu moyen mensuel selon le nombre d'enfants dans la famille, pour quelques pays 14/

	Revenu moyen mensuel d'un ouvrier ou employé travaillant au service de l'Etat	Année	Part relative des prestations dans le revenu moyen mensuel pour : (en pourcent)				
			1e.enf.	2e.enf.	3e.enf.	4e.enf.	5e.enf.
Bulgarie (lev)	148	1976	3,4	13,5	37,2	40,5	44,0
Hongrie (florints)	2.976	1976	43,4	16,8	32,3	43,0	54,1
Rép.dém.allemande(marks)	713	1969	2,8	5,6	9,8	18,2	28,1
Pologne (zlotys)	3.969	1976	4,0	10,3	18,9	25,5	37,0
Roumanie (lei)	1.964	1976	8,2	16,8	26,5	36,2	45,8
Tchécoslovaquie (kroner)	2.369	1976	3,8	18,2	37,2	54,0	64,2
Yougoslavie (dinars)	1.592	1972	1,7	3,2	4,5	5,7	6,3

14/ Valentina Bodrova; "The family as an object of Demographic Policy in the Socialist Countries of Europe"; 4th European Population Seminar; Athens 2-5 September 1979.

Tchécoslovaquie). Comme on aura pu le constater au cours de ce paragraphe, deux systèmes d'allocations familiales coexistent dans les pays développés: un système à montant progressif et un système à montant non progressif. Le caractère progressif des allocations a souvent été cité comme critère de distinction entre politiques familiales à objectif démographique et politiques familiales à objectif social: étant entendu que le fait d'avoir un système d'allocations familiales progressif suffisait pour classer une politique familiale dans la catégorie des politiques pronatalistes. L'exemple de pays comme les Pays-Bas où les allocations sont très progressives, montre que ce critère est peut-être nécessaire, mais certainement pas suffisant pour classer un pays dans la catégorie des pays pronatalistes.

Aux avantages financiers directs peuvent s'ajouter des avantages financiers indirects, tels que compensation des frais d'éducation, allant jusqu' à la gratuité scolaire complète, priorité d'accès aux logements à bon marché, prêts et subventions pour l'acquisition de logements, réduction sur les transports publics (en Belgique, cette réduction est accordée à tous les membres d'une famille, après la naissance du 3ème enfant, et les parents conservent cet avantage à vie) etc. En Tchécoslovaquie,15/ par exemple, les frais de placement des enfants dans les crèches et les jardins d'enfants, les repas scolaires, l'achat de vêtements, et autres biens et services nécessaires à l'éducation et à l'élevage de l'enfant sont pris en charge par l'Etat au prorata des revenus des parents. Les loyers, dans les logements dont l'Etat est propriétaire, peuvent être réduits jusqu'à 50 p. 100 selon le nombre d'enfants à charge. Des prêts, à taux d'intérêts très faible, atteignant jusqu'à 30.000 couronnes sont octroyés aux jeunes couples âgés de moins de 30 ans, pour acheter meubles (taux d'intérêt: 2,5 p. 100) et logement, (taux d'intérêt: 1 p. 100). Du montant à rembourser sont déduits 2.000 couronnes au premier anniversaire du premier enfant et 4.000 couronnes au premier anniversaire de chacun des autres enfants. Une mesure semblable existe en République démocratique d'Allemagne: les remboursements de prêts au logement sont progressivement annulés au fur et à mesure de la naissance des enfants et à la naissance du 3ème, la dette s'éteint.16/ D'autre part, si l'aide financière apportée aux familles n'est pas négligeable, cependant, la croissance de cette aide n'a pas été suffisante dans certain pays pour maintenir le pouvoir d'achat des familles: revenu réel et salaire ayant augmenté plus rapidement, les familles se sont relativement appauvries. Ainsi en France, les allocations familiales s'établissaient en 1975 à l'indice 638,8 (base 100 en 1946) pour une famille de deux enfants et à 1.376,6 pour une famille de 5, mais l'indice du salaire horaire atteignait 3.169.3 (base 100 en 1946) et celui des prix, 1.190,8 en 1975.

15/ Thomas Frejka, "Fertility trends and policies : Czechoslovakia in the 1970s"; The Population Council, working paper No. 54, February 1980.

16/ Jacqueline Hecht, "La politique de population de la République démocratique allemande, mai 1979"; Institut National d'Etudes Démographiques, document miméographié.

Certains pays ont également donné la priorité à d'autres problèmes sociaux, considérés comme plus urgents à résoudre (pension de vieillesse, allocation-chômage, etc.). Ainsi en France encore, l'indice des bénéfices sociaux se montait à 232,3 en 1973 (base 100 en 1962), mais l'indice des prestations familiales n'atteignait que 141,9 (1973).17/

D'autre part, les prestations familiales ne sont pas toujours équitablement réparties selon le niveau des revenus des familles: toutes les prestations n'évoluent pas selon le même rythme et elles ne sont pas attribuées dans les mêmes conditions à toutes les familles. Par exemple, en France, si l'on calcule en valeur absolue, les avantages accordés à une famille-type selon son niveau de revenu, on s'aperçoit que leur montant, élevé pour les titulaires de bas revenus, diminue lorsqu'on passe aux revenus moyens, mais augmente à nouveau pour les titulaires de revenus élevés.18/ L'exemple de la France a été choisi à dessein parce qu'il illustrait très bien notre propos. Il faut cependant signaler que de gros efforts ont été entrepris par le gouvernement de ce pays pour corriger ces "disparités".19/

3. Mesures tendant à concilier maternité et activité

Un troisième type d'intervention est constitué par l'ensemble des mesures qui visent à concilier l'activité professionnelle de la femme et la maternité. Dans les pays de l'Europe de l'Est, ce type d'intervention a pris un développement considérable. En effet, dans ces pays, confrontés à un problème de pénurie de main-d'oeuvre, le recours à l'immigration étrangère étant limité et l'activité féminine élevée, la seule solution pour résoudre à long terme le problème, consistait à élever la fécondité, tout en permettant aux femmes de poursuivre leur activité professionnelle. Il fallait donc offrir à celles-ci les conditions favorables leur permettant de jouer simultanément leur rôle de mère et de travailleuse. C'est ainsi qu'en République démocratique allemande, Hongrie et Tchécoslovaquie, des crèches et des jardins d'enfants ont été créés pour permettre aux mères de famille de concilier travail et élevage de l'enfant en bas âge. Des congés d'études sont offerts aux femmes pour leur permettre d'améliorer leur formation professionnelle. En plus des congés de maternité, des congés payés ont été également institués pour l'éducation de l'enfant: en République démocratique allemande, ce congé, offert aux mères de deux enfants, donne droit au paiement pendant un an d'une indemnité calculée sur la base du salaire moyen d'un ouvrier. En outre, la durée hebdomadaire

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17/ Sheila B. Kamerman and Alfred J. Kahn, édition; "Government and Families in Fourteen Countries", Columbia University Press, New York, 1978. Chapitre consacré à la France: Nicole Questiaux and Jacques Fournier.

18/ Jacques Fournier et Nicole Questiaux, "Le pouvoir du social", Economie en liberté, Presses Universitaires de France, 1979. Le montant total des avantages familiaux accordés à une famille de 3 enfants avec salaire unique s'est élevé en 1976 à 12.626 francs pour une famille ouvrière, 8.966 francs pour une famille de cadre moyen et 12.209 pour une famille de cadre supérieur.

19/ Rapport de synthèse des travaux du Haut Comité de la Population, Rapport remis à M. Matteoli, Ministre du Travail et de la Participation, Président du Haut Comité de la Population, Paris, juin 1980.

de travail des mères de famille a été réduite sans diminution de salaire.20/

En Tchécoslovaquie,21/ le congé de maternité a été prolongé de 18 à 26 semaines (35 semaines si la mère est seule) et la mère reçoit pratiquement son plein salaire durant cette période. En plus, le gouvernement a créé un système d'allocations de naissance, conçu de façon à permettre à la mère de prolonger ses congés de maternité au-delà des délais normalement prévus. Ainsi, une travailleuse qui désire rester à la maison pour élever un enfant de moins de deux ans, et à la condition d'avoir au moins un autre enfant en âge scolaire, peut recevoir des allocations mensuelles variant de 500 à 1.200 couronnes (le montant est déterminé en fonction du nombre d'enfants à charge en-dessous de deux ans).

La Hongrie offre des dispositions identiques: à la fin de son congé de maternité (20 semaines avec salaire complet) la travailleuse qui désire rester à la maison pour élever elle-même son enfant, peut le faire pour une période de trois ans. Durant cette période, elle reçoit une allocation équivalente à environ le tiers du salaire moyen des travailleuses.22/

Les pays de l'Europe de l'Ouest commencent eux aussi à prendre des dispositions du même ordre, bien que l'objectif pronataliste de ces mesures soit nettement moins affirmé. La Suède a créé récemment un congé d'éducation de l'enfant dont le père ou la mère peut être bénéficiaire et cela sans conditions démographiques préalables.23/ D'autres pays de l'Ouest transforment le congé de maternité en véritable congé d'éducation, par allongement progressif: ainsi en République fédérale d'Allemagne, le congé de maternité a été porté de 4 à 6 mois et durant ce temps, le salaire que les femmes abandonneront leur sera remboursé par l'Etat jusqu'à concurrence de 750 marks par mois.24/ En Italie, le congé de maternité s'étend à 5 mois, mais un congé supplémentaire 25/ de 6 mois peut être octroyé.26/ En France, le congé de maternité est de 4 mois, mais est étendu à 6 mois pour la naissance d'un troisième enfant.27/

20/ Jacqueline Hecht, "La politique de Population de la République démocratique allemande, op.cit.

21/ Thomas Frejka, "Fertility trends and policies : Czechoslovakia in the 1970s", op.cit.,

22/ Dr. Egon Szabady, "Effects of Child Case Allowance on Fertility", 4th European Population Seminar, Athens, 2-5 October 1979.

23/ Population Bulletin, "Sweden Faces Zero: Population Growth", A publication of the Population Reference Bureau, Inc. Vol. 35, No. 2, June 1980.

24/ "Le Monde" édition 17 mai, 1979 (Paris, France).

25/ Le congé supplémentaire facultatif peut être demandé par le père, si la mère ne le réclame pas ou si le père assume seul la charge de l'enfant.

26/ Comparative Tables of the Social Security Systems in the Member States of the European Communities; op.cit.

27/ "Le Monde" édition 14 juillet, 1980 (Paris, France).

Nous avons déjà noté certains obstacles rencontrés par les pays développés, concernés par des niveaux de fécondité perçus trop bas et qui ont fait choix d'intervenir pour les modifier. Essayons maintenant d'indiquer quelques conséquences d'ordre général du choix de ces options politiques. On sait que les couples tendent de plus en plus à avoir le nombre d'enfants souhaité et pas d'avantage. D'autre part, la polarisation croissante de choix familiaux sur deux enfants correspond, au niveau macrodémographique, à l'adoption d'un modèle de population légèrement décroissante. Les politiques pronatalistes qui visent un modèle de population légèrement croissante ou au moins stationnaire sont contraintes de privilégier dans leur intervention les familles de trois enfants dont l'évolution conditionne précisément la réalisation de leur objectif de croissance ou de stationnarité. Ce choix, justifié pour des raisons d'efficacité démographique, s'inscrit en quelque sorte à contre courant de la tendance très forte à l'égalité des charges de fécondité, telles qu'elle s'exprime dans la généralisation de la norme familiale de deux enfants.28/

L'histoire démographique de l'Europe au XXème siècle montre que la charge du renouvellement des générations a été longtemps assurée et cela, sans intervention gouvernementale dans la plupart des cas, par une minorité de familles fécondes situées aux deux extrémités de l'échelle sociale. Même si l'Etat s'engageait à fond dans une politique de soutien, il n'est pas certain qu'aujourd'hui une telle inégalité dans la répartition des charges de fécondité soit acceptée par les mêmes catégories de la population, tant il est vrai que la légitimité de ses interventions sociales repose maintenant sur une attente profondément égalitaire.

28/ Cependant l'évolution récente de la fécondité dans plusieurs pays développés paraît bien infirmer cette problématique: en Belgique, aux Etats-Unis, en République fédérale d'Allemagne, on assiste à une reprise de la natalité. Est-ce le résultat des politiques gouvernementales ou tout simplement une confirmation des thèses sur les cycles longs de la fécondité? Seule une observation étendue sur plusieurs années permettra de trancher.

Jean Bourgeois-Pichat, "The Demographic Situation in Europe with Emphasis on Fertility, Development and Urbanization". Beijing International Round Table Conference on Demography, 1980. Beijing, 20-27 October 1980.

B. PAYS EN DEVELOPPEMENT

Près de la moitié des pays en développement, 59 pays sur 126 (soit 47 p. 100) souhaitent une fécondité plus basse, une proportion à peu près équivalente (35 pays, soit 42 p. 100) se montre satisfaite du niveau actuel tandis que 14 pays seulement (soit 11 p. 100) souhaitent une fécondité plus élevée (cf tableau 1). Peu de changements sont intervenus au niveau des perceptions depuis 1978, par contre, un nombre important de pays ont décidé de mettre en oeuvre des politiques en vue de modifier ou de maintenir la fécondité à son niveau. Nous noterons plus loin ces changements.

Au niveau régional, les pays de la CESAP sont les plus nombreaux à souhaiter une fécondité plus basse: 63 p. 100 des pays; viennent ensuite les pays de la CEPAL, 50 p. 100, ceux de la CEA, 43 p. 100, et de la CEAO, 16 p. 100 seulement. En termes de population, c'est bien entendu encore dans la région de la CESAP que l'insatisfaction est la plus grande. La proportion de pays souhaitant un taux de fécondité plus élevé est à peu près la même dans les différentes régions: 13 p. 100 des pays de la CEPAL, 10 p. 100 de la CEA, 8 p. 100 de la CEAO et 7 p. 100 de la CESAP. En revanche, la proportion des pays satisfaits du taux varie considérablement d'une région à l'autre: la CEAO vient en tête (75 p. 100 des pays estimant le niveau de la fécondité satisfaisant), ensuite la CEA (47 p. 100), la CEPAL (37 p. 100) et la CESAP (30 p. 100).

Au niveau des politiques proprement dites, la majorité des pays non satisfaits prennent des mesures pour modifier une situation jugée non acceptable: 10 pays sur 14 ont des politiques pour remonter le taux et 38 pays sur 59 pour le réduire. Parmi les pays satisfaits, 21 seulement sur 53 prennent des mesures pour maintenir le niveau.

Au niveau régional, les pays de la CESAP sont de nouveau les plus nombreux à intervenir pour modifier des taux, jugés trop élevés: dans cette région, 16 pays sur 19 interviennent pour réduire le taux, 9 pays sur 15 dans la région de la CEPAL, 12 pays sur 22 dans celle de la CEA et aucun dans la région de la CEAO.

Nous devons maintenant examiner dans chacune des régions, comment les pays perçoivent leur niveau de fécondité, quels changements sont intervenus depuis 1978, et quels types de mesures mettent en oeuvre les pays qui ont décidé d'intervenir. Nous avons regroupé, dans chaque région, les différentes mesures dans les catégories suivantes: mesures légales (accès à la contraception, avortement, stérilisation, âge au mariage), mesures techniques et administratives (intégration des programmes de régulation des naissances dans les services de santé, les communautés de base, etc.), mesures économiques d'incitation et de persuasion (primes versées lors d'une stérilisation, annulation des abattements d'impôts sur le revenu lors de la naissance du nième enfant, etc.), mesures psychologiques (campagnes d'information et d'éducation, etc.) et action sur les déterminants

socio-économiques de la fécondité (éducation, amélioration du statut de la femme, distribution des revenus, etc.).29/

Nous avons indiqué également, dans quelles perspectives se situaient ces mesures: politiques pronatalistes ou antinatalistes, politiques de bien-être individuel, dans les pays satisfaits du taux. Les pays pronatalistes souhaitent, dans la plupart des cas, un taux de fécondité plus élevé, mais certains d'entre eux peuvent être satisfaits de leur taux. Les pays antinatalistes souhaitent en général un taux de fécondité plus bas, mais certains d'entre eux peuvent également être satisfaits de leur taux, tandis que les pays qui mettent en oeuvre des mesures en vue d'améliorer le bien-être individuel sont, dans l'emsemble, satisfaits de leur taux, bien que certains d'entre eux puissent souhaiter un taux plus bas ou plus élevé.

CEA

En 1980, 5 pays sur 51 souhaitent un taux plus élevé et 22 un taux plus bas, tandis que 24 pays se déclarent satisfaits du taux actuel. Peu de changements sont intervenus depuis 1978: la République-Unie du Cameroun, qui considérait son taux de fécondité trop bas, le considère aujourd'hui trop élevé, et l'Algérie, qui en 1978 était satisfaite de son taux, le considère également aujourd'hui trop élevé. Ces deux pays souhaitent en même temps un taux d'accroissement plus bas mais n'ont pas encore adopté de mesures spécifiques. Plusieurs pays satisfaits du taux ont maintenant décidé de mettre en oeuvre des politiques, soit pour maintenir le taux à son niveau actuel, soit pour améliorer les conditions du bien-être individuel, (cf tableau 11). Au total donc, 3 pays sur 5 souhaitent un taux plus élevé et prennent des mesures en conséquence ainsi que 14 pays sur 22 désirant un taux plus bas. Parmi les pays satisfaits du taux, 8 sur 24 mettent en oeuvre des politiques pour maintenir le taux à son niveau.

Tous les pays souhaitant un taux de fécondité plus élevé, souhaitent en même temps un taux d'accroissement plus élevé. Un seul, la Côte d'Ivoire, se déclare satisfait du taux de fécondité, mais souhaite un taux d'accroissement plus élevé (comptant atteindre cet objectif par une action sur d'autres composantes que la fécondité: la mortalité et les migrations). Les politiques de fécondité mises en oeuvre par les premiers visent donc bien à accroître la population, tandis que celles de la Côte d'Ivoire ont un double objectif: améliorer le bien-être individuel et agir sur les composantes de la croissance.

1. Mesures légales

Une première catégorie de mesures que les gouvernements peuvent mettre en oeuvre est constituée par des mesures légales en matière d'accès aux

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29/ Bernard Berelson, W. Parker Maldin, Sheldon J. Segal, "Population: Current Status and Policy Options". Center for Policy Studies, Working Papers, No. 44, May 1979. The Population Council.

Tableau 11. Changements dans les perceptions gouvernementales concernant le taux global de fécondité, juillet 1978 - juillet 1980

Pays situés dans la Région de la CEA

	Perceptions gouvernementales concernant l'acceptabilité du taux actuel de fécondité et désir d'intervention en vue de le modifier						
	Taux non satisfaisants parce que trop bas; taux plus élevés souhaitables		Taux satisfaisants		Taux non satisfaisants parce que trop élevés; taux plus bas souhaitables		Total
	Intervention pour augmenter les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Mais mesures d'encouragement ou de dissuasion mises en oeuvre pour maintenir les taux	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Ni mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention pour diminuer les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	
	I	II	III	IV	V	VI	
Nombre de pays dans chaque catégorie en 1978	3	3	2	23	7	12	50
Changements dans les perceptions concernant l'acceptabilité du taux actuel et désir d'intervention en vue de le modifier durant la période 1978-1980	b	-Rep. unie du Cameroun	b	-Algérie -Benin -Mali -Mauritanie -Niger -Togo -Haute-Volta	-Rwanda	b	7
	b	b	+Benin +Mali +Mauritanie +Niger +Togo +Haute-volta	b	+Algerie +Rep.-unie du Cameroun	+Rwanda +Zimbabwe a/	
Nombre de pays dans chaque catégorie en 1980	3	2	8	16	8	14	51

a/ Les pays soulignés sont devenus indépendants durant la période 1978-1980

b) Pas de changement

(+) Pays entrant dans cette catégorie

(-) Pays changeant de catégorie

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

méthodes modernes de contraception, d'avortement et de stérilisation.

Le tableau 3 indique que 35 pays autorisent et soutiennent directement (25 pays) ou indirectement (10 pays) la diffusion des moyens contraceptifs. Parmi ces pays, 21 sont antinatalistes et 14 sont satisfaits du taux. Seul, le gouvernement des Comores, bien qu'étant antinataliste, autorise la diffusion mais n'y apporte aucun soutien. Cinq pays limitent l'accès aux moyens contraceptifs et 11 l'autorisent, mais sans soutien gouvernemental. Parmi les 5 premiers, 3 ont une politique pronataliste (Gabon, Guinée Equatoriale et Jamahiriya Arabe Libyenne) et 2 sont satisfaits du taux: Malawi et Tchad. (situation en 1978). Parmi les 11 autres, 2 sont pronatalistes (République Centrafricaine et Guinée) et 9 sont satisfaits du taux. Il n'y a donc pas de doute que les pays africains pronatalistes limitent l'accès à la contraception, tandis que les antinatalistes le favorisent. Ceux qui sont satisfaits de leur taux se partagent en deux groupes à peu près égaux de pays, qui favorisent ou limitent la diffusion de la contraception.

Dans les pays de la CEA, les dispositions légales concernant l'avortement sont restées très restrictives. Un seul pays (antinataliste), la Tunisie, autorise l'avortement "à la demande" depuis 1973, et deux autres seulement, la Zambie depuis 1972 et le Congo dans la pratique (tous deux satisfaits du taux), autorisent l'avortement pour des raisons d'ordre socio-économique en vue du bien-être individuel (cf tableau 4). En Zambie, la loi prévoit qu'une grossesse peut être terminée, si sa continuation risque de porter préjudice à la santé physique ou mentale des enfants déjà nés. Toute demande d'avortement, introduite pour raison socio-économique ou pour protéger la santé physique ou mentale de la mère, est toujours considérée en fonction de son âge, des conditions matérielles, présentes ou futures, de la famille. Au Congo, où la loi date de 1810 et n'est plus appliquée (une nouvelle loi est actuellement en discussion et les avortements sont pratiqués fréquemment), un avortement est autorisé, sur avis d'un travailleur social, si toute nouvelle naissance risque de créer pour la mère ou sa famille des conditions de vie difficiles.

En général dans les pays africains, des dispositions légales autorisant l'avortement pour risque à la santé mentale de la mère, risque de naissance anormale ou pour raisons juridiques sont rarement mentionnées. Par contre, la totalité d'entre eux, c'est-à-dire les 45 pays pour lesquels nous avons des informations, autorisent l'avortement pour sauver la vie de la mère, et une vingtaine de pays pour préserver sa santé physique.

Les pénalités prévues par les codes, en cas de transgression de la loi, sont en général très sévères. Mais il est difficile de savoir si elles sont effectivement appliquées. Les peines prévues pour ceux qui pratiquent un avortement s'étendent en moyenne de deux à dix ou quatorze ans de prison, avec ou sans amende. Si l'avorteur est médecin ou membre d'une profession médicale, les peines sont plus sévères encore et souvent assorties d'une suspension d'activité professionnelle, qui peut être à vie (exemple du Tchad). Les peines prévues pour les femmes qui se font avorter sont moins sévères: elles s'étendent de quelques jours (15 jours en République-Unie

du Cameroun) à cinq ou sept ans d'emprisonnement. Un seul pays, le Libéria, (loi de 1979) décriminalise l'avortement provoqué par la femme enceinte elle-même, ainsi que toute méthode qu'elle pourrait utiliser, pour empêcher la nidation de l'ovule fécondé. A titre d'exemple, mentionnons qu'en Tunisie, le nombre d'avortements reste peu élevé: 21.000 en 1977; le taux d'avortement est passé de 3,0 p. 1000 femmes (15-44 ans) à 10,9 p. 1000 l'année qui a suivi la libéralisation de l'avortement (1974) et s'établit en 1977 à 16,8 p. 1000.30/

La stérilisation volontaire est encore peu répandue en Afrique et peu de pays l'ont libéralisée jusqu'à présent. En 1978, on estimait le nombre de couples stérilisés pour des motifs contraceptifs à 1 million (0,5 million en 1970).31/ Dans le cadre de la stérilisation volontaire, 7 pays autorisent la stérilisation "à la demande", un seul pour raisons d'ordre socio-économique, et trois pour raison de régulation des naissances (cf tableau 5).

La stérilisation est autorisée "à la demande" en Ethiopie, pays satisfait de son taux, et en Ouganda, pays antinataliste, mais les dispositions légales restent très restrictives: en Ethiopie, la mère doit être âgée de plus de 35 ans, avoir déjà au moins 5 enfants vivants et vivre dans des conditions socio-économiques difficiles. En Egypte, pays antinataliste, bien que le statut légal ne soit pas clairement défini, la stérilisation est autorisée en pratique "à la demande", si la femme a au moins 35 ans et un minimum de 3 enfants vivants, dont un garçon. En Tunisie, pays antinataliste lui aussi, le gouvernement encourage la stérilisation et l'a déclarée un moyen acceptable de limitation de la famille: elle est autorisée "à la demande", si la femme a au moins 4 enfants. On estimait à 3.000, le nombre de couples stérilisés en Tunisie en 1965 et à 40.500 en 1977. En 1965, 2,7 p. 100 des acceptants des services de planification familiale utilisaient la stérilisation comme moyen contraceptif et cette proportion s'élevait à 11,3 en 1976, après être montée jusqu'à 21,2 p. 100 en 1974.32/ En Afrique méridionale, la stérilisation est autorisée "à la demande" et pour motif de régulation des naissances au Botswana, et "à la demande" en Afrique du Sud, tous deux, pays antinatalistes. Les dispositions légales, dans ces deux pays, exigent des requérants un consentement total, la maturité et une complète information sur les conséquences de l'opération.

30/ Christopher Tietze, "Induced Abortion : 1979",op.cit. and Demographic Yearbook 1978, United Nations, op.cit.

31/ C.P. Green, "Voluntary Sterilization : World's Leading Contraceptive Method", op.cit. and R.T. Ravenholt, "Voluntary Sterilization : A Decade of Achievement", op.cit.

32/ Jean-Paul Sardon, "La Stérilisation dans le monde. I. Aperçus médicaux et législatifs", Population, No. 2, mars-avril 1977 et "La Stérilisation dans le monde. II. Données statistiques", Population No. 3, mai-juin 1979.

La plupart des gouvernements qui ont libéralisé l'avortement ou la stérilisation, ou qui l'autorisent de fait, sont antinatalistes; quelques-uns cependant sont des pays satisfaits de leur taux (Zambie, Congo, Ethiopie), mais aucun parmi eux n'est pronataliste.

D'autres mesures légales, qui peuvent avoir un effet significatif sur la fécondité, ont également été prises par un certain nombre de gouvernements, antinatalistes surtout. On peut mentionner les modifications de l'âge minimum légal au mariage et notamment celui de la femme. Ce dernier a été porté à 17 ans en Tunisie (1974), à 16 ans au Lesotho (1974), à 15 ans à l'Ile Maurice (1976) etc.33/ Un autre type de mesure légale qu'ont pris certains pays, consiste à interdire la polygamie (Tunisie) ou tout au moins à la décourager.

2. Mesures techniques

Nous avons noté que dans les pays de la CEA, les mesures d'ordre légal étaient un instrument important aux mains des gouvernements. Jusqu'à présent, quelques pays seulement mettent en oeuvre d'autres types de mesures, notamment les mesures d'ordre techniques.

Dans les pays pronatalistes, principalement parmi ceux qui sont confrontés à des problèmes de population sous-féconde (notamment en Afrique équatoriale et occidentale), les politiques sont orientées vers une amélioration des conditions sanitaires et le développement rural (Congo, Gabon). En Tanzanie d'autre part, où l'objectif de politique de fécondité vise à améliorer le bien-être des familles, un vaste programme de "villagisation" a été entrepris, pour regrouper une population dispersée, la réunir en village et la doter ainsi d'une infrastructure administrative, économique, culturelle, etc. Chaque village dispose d'un service de santé maternelle et infantile, responsable entre autres, de l'amélioration des conditions d'hygiène, de la nutrition, mais aussi de toutes les questions relatives à la régulation des naissances.34/

Dans les pays antinatalistes, les programmes de régulation des naissances sont en général intégrés aux services de santé, particulièrement aux services de santé maternelle et infantile. Le tableau 12 indique pour quelques pays, la part que représente dans le budget national, le budget du ministère de la Santé et la part que celui-ci consacre aux programmes de régulation des naissances. On note qu'à l'Ile Maurice,

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33/ Population Reports, "Age at Marriage and Fertility", Série M, Number 4, November 1979, Population Information Program, the John Hopkins University.

34/ "National Experience in the Formulation and Implementation of Population Policy : United Republic of Tanzania", Department of International Economic and Social Affairs, United Nations, New York, 1978.

10 p. 100 du budget national est consacré au ministère de la Santé, qui en dépense 5 p. 100 pour les programmes de régulation des naissances. En revanche, en République-Unie de Tanzanie, la proportion du budget consacrée à ces programmes est très faible.

Les gouvernements confient de plus en plus aux communautés locales la responsabilité de la mise en oeuvre des programmes de régulation des naissances: diffusion du concept de familles moins nombreuses, recrutement d'acceptants, distribution de moyens contraceptifs, etc. Des groupements sociaux, associations, secteur industriel, etc. sont également appelés à jouer le même rôle. En Tunisie, dans les grandes entreprises comme les Chemins de fer, la planification de la famille fait partie des programmes sociaux mis en place au profit du personnel et la loi impose aux petites entreprises, qui se groupent pour cela, d'inclure dans leur dispensaire, un service de régulation des naissances.35/

Plusieurs pays confient à du personnel non médical la responsabilité des services de régulation des naissances, et en particulier aux sages-femmes qui ont en général la pleine confiance des femmes, en milieu rural surtout. En République-Unie du Cameroun, Ghana36/, Kenya, Libéria, Sénégal37/, Sierra-Leone, des programmes ont été mis au point, parfois simplement à titre expérimental, mais dans certains cas déjà, appliqués à l'échelle du pays, pour utiliser les services des sages-femmes comme agents des services de régulation des naissances.38/

L'Egypte a fait un effort tout particulier pour étendre le réseau de distribution des moyens contraceptifs, en utilisant les circuits commerciaux et non commerciaux.

35/ L'association des communautés locales et de certains groupes particuliers de la communauté aux programmes gouvernementaux de régulation des naissances constitue ce qu'on appelle la participation communautaire aux programmes.

Margaret Wolfson, "Changing Approaches to Population Problems : Development Centre of the Organization for Economic Co-operation and Development in Co-operation with the World Bank", Paris, 1978.

36/ "National Experience in the Formulation and Implementation of Population Policy : Ghana", United Nations, op.cit.

37/ "Population Policy Compendium : Senegal", A joint publication of the Population Division of the United Nations Department of International Economic and Social Affairs and the United Nations Fund for Population Activities.

38/ "Population Reports", Family Planning Programs, Série J, Number 22, May 1980.

Tableau 12. Part du budget national consacré à la santé et aux programmes de régulation des naissances pour quelques pays.

Pays et année	Part du budget national consacré aux programmes de régulation des naissances (en pour cent)	Part du budget du ministère de la Santé consacré aux programmes de régulation des naissances (en pour cent)	Part du budget national consacré au ministère de la Santé (en pour cent)
Bangladesh (1976)	2,4	-	-
Bolivie (1976)	0,0001	0,12	1,1
République Dominicaine (1977)	0,17	1,2	14,4
El Salvador (1977)	0,7	6,2	11,2
Inde (1978)	0,52	11,1	4,7
Indonésie (1978)	0,2	23,2	1,0
République de Corée (1978)	0,18	16,1	1,11
Malaisie (1978)	0,11	-	-
Ile Maurice (1978)	0,6	5,2	10,9
Philippines (1978)	0,4	11,8	3,6
Singapour (1979)	0,1	1,5	4,8
République-Unie de Tanzanie	0,05	0,77	6,4

Source: Dorothy L. Norman, Ellen Hofstatter. "Population and Family Planning Programs, a compendium of data through 1978". A Population Council Fact Book, 10th edition.

3. Mesures économiques d'incitation et de dissuasion

Les mesures économiques d'incitation et de dissuasion sont peu utilisées dans les pays africains, surtout si l'on compare cette région avec celle de la CESAP.

Parmi les pays pronatalistes, certains mettent en oeuvre des mesures d'incitation d'ordre financier, comparables à celles que l'on trouvait dans les pays développés. Ainsi au Gabon (loi de 1975) et au Congo (loi de 1956) des prestations familiales sont accordées aux travailleurs (un système particulier existe pour les employés de l'Etat): allocations familiales versées pour les enfants jusqu'à l'âge de 16 ans (17 ans s'ils sont apprentis, 20 ans, étudiants), allocations pré-natale et prime à la naissance.39/

Dans les pays antinatalistes, les mesures d'incitation les plus simples, et qui sont aussi les plus anciennes, consistent à distribuer gratuitement des produits contraceptifs et à faire subventionner par l'Etat en tout ou en partie, le coût des avortements et des stérilisations, dans les pays où ceux-ci sont autorisés.

Le tableau 13 indique pour quelques pays les services aui sont offerts gratuitement ou fournis à coût réduit. On note que la plupart des pays offrent gratuitement l'insertion du stérilet ou la distribution de condoms, tandis que les pilules sont vendues à prix très réduits. Peu de pays africains autorisent la stérilisation volontaire comme nous l'avons mentionné précédemment. En plus de la gratuité ou des bas coûts des services, de nombreux pays offrent une prime financière aux acceptants de la contraception pour les inciter à accepter cette méthode et à persévérer dans son utilisation. Certains pays offrent également une prime financière aux "diffuseurs" des moyens de contraception et parfois même aux fournisseurs de produits contraceptifs (Botswana, Tunisie).

Dans l'île Maurice, une prime est offerte aux agents "diffuseurs" des moyens de régulation des naissances, mais cette prime est versée en deux versements (délai de 6 mois), le deuxième n'étant versé que si l'acceptant recruté persévère dans l'utilisation des moyens contraceptifs.

Parallèlement à ces mesures d'incitation, certains gouvernements recourent à des mesures de dissuasion: en Tunisie par exemple, le système d'allocations familiales est limité et dégressif du premier au quatrième enfant, 18 p. 100 du salaire pour le premier enfant, ensuite 16 p. 100, 14 p. 100 et 12 p. 100 pour le quatrième.40/

39/ Social Security Programs Throughout the World, 1979, Research Report No. 54, US Department of Health and Human Services, Social Security Administration, Office of Policy, Office of Research and Statistics.

40/ Social Security Programs Throughout the World, 1979, op.cit.

Tableau 13. Mesures financières directes d'incitation offertes aux utilisateurs de moyens contraceptifs, pour quelques pays

Pays et régions	Méthodes contraceptives			
	Stérilet	Pilule	Stérilisation	Condoms et autres moyens
Afrique				
Botswana	G 41/	CR	CR	CR
Egypte	G, I	CR, I	PP	CR
Ghana	G	CR	PP	CR
Kenya	G	G	PP	G
Ile Maurice	G, I	G, I	PP	G
Maroc	G	G	PP	G
Tunisie	G, I	G	G, I	G
Asie				
Bangladesh	G, I	G	G, I	G
Chine	G	G	G	G
Fidji	G	CR	G	CR
Inde	G, I	-	G, I	G
Indonésie	G	G	G	G
Iran	G	G	G	G
Malaisie	G	CR	G	G
Népal	G, I	G	G, I	G
Pakistan	G	CR	G	CR
Philippines	G	G	-	G
République de Corée	G, I	CR	G, I	CR
Singapour	CR	CR	CR	G
Sri Lanka	G	CR	G	CR
Thailande	G	G	CR	G
Turquie	G	-	-	-
Amérique latine				
Colombie	G	G	-	G
République Dominicaine	G	G	-	G
El Salvador	G	G	-	G
Guatemala	CR	CR	-	-
Jamaïque	G	CR	-	-
Mexique	G	G	-	G

Source: "The Role of Incentives in Family Planning Programmes", Policy Development Studies, No. 4, United Nations Fund for Population Activities.

41/ Signification des symboles:
G = gratuité des programmes
CR = services fournis à cout réduit
PP = pas de programme
G, I = gratuité des services et mesures d'incitation en faveur de l'acceptation du programme

4. Mesures psychologiques

Plusieurs pays africains antinatalistes ont mis sur pied des campagnes d'information en vue d'influer sur les motivations des couples en faveur de familles moins nombreuses. Des programmes d'éducation ont également été lancés à l'adresse des adultes et des jeunes, à travers les systèmes d'éducation formels et informels. Les problèmes d'interrelation entre population et développement économique et social, la santé, l'environnement, etc. font partie des programmes scolaires en Tunisie, Kenya et Egypte.42/

5. Action sur les déterminants socio-économiques de la fécondité

Un dernier axe d'intervention consiste à agir sur les déterminants socio-économiques de la fécondité, tels que l'éducation, la santé, l'emploi, la distribution des revenus, l'amélioration de la condition de la femme, etc.

Un effort d'intégration des programmes dans la stratégie générale du développement a été entrepris par plusieurs pays et certains se sont dotés dans cette perspective, d'un Comité national de population, placé directement sous l'autorité du Premier Ministre ou du ministre de la planification (Tunisie, Egypte).

L'effort d'intégration a été poussé assez loin en Egypte: la stratégie consiste à introduire, au niveau local, la composante population dans toutes les activités de développement économique et social.

Le Comité de la population et de la planification de la famille égyptien a identifié neuf variables sur lesquelles il est nécessaire d'agir, en vue d'améliorer les conditions de vie et de diminuer la fécondité (les deux objectifs étant étroitement interdépendants); citons parmi ces variables, le niveau socio-économique de la famille, la main-d'oeuvre féminine, la mécanisation de l'agriculture et l'industrialisation, la réduction de la mortalité infantile, l'éducation, etc. et les services de planification de la famille, comme élément intégré aux services sociaux en général.

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En 1980, 4 pays sur 30 souhaitent un taux plus élevé et 15 un taux plus bas; 11 pays se déclarent satisfaits du niveau actuel du taux. Peu de changements sont intervenus depuis 1978: parallèlement à son changement de perception concernant l'accroissement naturel de la population, le Chili, qui considérait son taux de fécondité trop élevé en 1978, le considère maintenant trop bas. Durant la période quelques pays ont décidé de mettre en oeuvre des politiques, soit pour maintenir le taux à son niveau ou améliorer les conditions du bien-être individuel, soit pour modifier le taux perçu trop élevé (cf tableau 14). En 1980, 3 pays sur 4 souhaitant un taux plus élevé et 13 sur 15 désirant un taux plus bas ont des

42/ Margaret Wolfson, "Changing Approaches to Population Problems", op.cit.

Tableau 14. Changements dans les perceptions gouvernementales concernant le taux global de fécondité, juillet 1978- juillet 1980

Pays situés dans la Région de la CEPAL

	Perceptions gouvernementales concernant l'acceptabilité du taux actuel de fécondité et désir d'intervention en vue de le modifier						
	Taux non satisfaisants parce que trop bas: taux plus élevés souhaitables		Taux satisfaisants		Taux non satisfaisants parce que trop élevés: taux plus bas souhaitables		Total
	Intervention pour augmenter les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Mais mesures d'encouragement ou de dissuasion mises en oeuvre pour maintenir les taux	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention pour diminuer les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	
	I	II	III	IV	V	VI	
Nombre de pays dans chaque catégorie en 1978	3	-	-	11	5	8	27
Changements dans les perceptions concernant l'acceptabilité du taux actuel et désir d'intervention envue de le modifier durant la période 1978-1980	b	b	b	-Panama -Colombie	-Bahamas -Costa Rica -Chile		
	b	+Chili	+Panama +Colombie	b	b	+Bahamas +Dominique a/ +Saint -Lucie a/ +Saint -Vincent-et-Grenadines a/ +Costa Rica	
Nombre de pays dans chaque categories en 1980	3	1	2	9	2	13	30

a/ Les pays soulignés sont devenus indépendants durant la période 1978-1980
b) Pas de changement
(+) Pays entrant dans cette catégorie
(-) Pays changeant de categorie

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

politiques ainsi que 2 pays sur 11 qui se déclarent satisfaits du taux.[43/]

Les 4 pays souhaitant un taux de fécondité plus élevé souhaitent en même temps un taux d'accroissement plus élevé. Le Paraguay est le seul pays de la région qui souhaite augmenter le taux d'accroissement mais qui se déclare en même temps satisfait du taux de fécondité, comptant sur d' autres variables démographiques (migrations internationales) pour atteindre son objectif.

1. Mesures légales

Le tableau 3 indique que 25 gouvernements autorisent et soutiennent directement (24 pays) ou indirectement (1) l'accès et la diffusion des moyens contraceptifs. Parmi ces pays, 15 sont antinatalistes et 9 sont satisfaits du taux. Le Chili est le seul pays pronataliste à autoriser et à soutenir l'accès aux moyens contraceptifs. Le Pérou, qui souhaite un taux d'accroissement plus bas, a cependant retiré récemment son soutien direct aux méthodes modernes de contraception, dispensées dans les centres gouvernementaux. Parmi les pays pronatalistes, l'Uruguay limite l'accès aux moyens contraceptifs et l'Argentine et Bolivie l'autorisent, mais sans support gouvernemental. Cette dernière position est aussi celle de la Guyane et Suriname, tous deux satisfaits du taux. Les gouvernements des pays d'Amérique latine, comme ceux de l'Afrique, utilisent donc les mesures légales pour soutenir leurs politiques: les pays antinatalistes autorisent et soutiennent l'accès aux moyens contraceptifs tandis que les pays pronatalistes limitent ou ne soutiennent pas leur diffusion.

Les législations sur l'avortement restent très restrictives, quelque soit l'orientation générale de la politique de fécondité: antinataliste, pronataliste, etc. (cf tableau 4). Cuba, pays satisfait du taux de fécondité, autorise l'avortement "à la demande", les Bahamas, pays antinataliste et l'Uruguay, pays pronataliste, l'autorisent pour raisons socio-économiques, mais interprétées de façon assez restrictive. La quasi totalité des pays d'Amérique latine autorisent l'avortement pour sauver la vie de la mère mais 13 pays seulement, pour raison de risque à la santé.

Cependant, les pénalités prévues par la loi sont, dans l'ensemble, nettement moins sévères qu'en Afrique: de un à trois ans d'emprisonnement et souvent moins. En plus,de nombreuses circonstances atténuantes peuvent encore diminuer ces peines: pour sauver la réputation d'une femme enceinte suite à des relations illégitimes (adultère)(Mexique) ou criminelles (inceste, viol)(Colombie) ou si l'avortement est requis.pour des raisons de sérieuses difficultés économiques (Uruguay), etc. Dans certains pays, les peines sont modulées en fonction de la durée de la grossesse: ainsi au Costa Rica, la peine prévue pour l'avorteur ou la femme avortée est

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43/ Valeria Ramiréz y Fernando Toro, bajo la supervisión de Gerardo González, "La política de población en América latina", 1974-1978, Centro latinoamericano de demografia area de población y desarrollo, document miméographié.

l'emprisonnement de un à trois ans, mais cette peine est réduite à un emprisonnement de six mois à deux ans si le foetus a moins de six mois.

A titre d'exemple, mentionnons qu'à Cuba le nombre d'avortements s'élevait à 121.000 en 1976, soit un taux d'avortement de 61 p. 1000 femmes (15-44 ans). Le taux d'avortement a été en progression constante jusqu'en 1974 où il a atteint 69,5 p. 1000 mais il semble décroître depuis lors.44/

La stérilisation volontaire a été libéralisée beaucoup plus largement que l'avortement, particulièrement dans les pays antinatalistes d'Amérique centrale et des Caraïbes: le tableau 5 indique que 11 pays l'autorisent "à la demande" et 1 pour raisons socio-économiques. Dans les Caraïbes, 5 pays, Barbades, Cuba, République Dominicaine, Jamaïque et Trinité-et-Tobago autorisent la stérilisation volontaire "à la simple demande". Cependant, à Cuba, Jamaïque et surtout République Dominicaine, les dispositions légales sont restrictives: à Cuba, la femme doit être âgée de 32 ans et avoir plusieurs enfants et en Jamaïque, de préférence au moins 35 ans. Il semble que dans ce dernier pays, la stérilisation soit de plus en plus répandue: elle est en tout cas encouragée, puisque la ligature des trompes, opérée dans les hôpitaux gouvernementaux, est gratuite, En République Dominicaine, la loi prévoit une modulation très explicite des conditions: la femme doir être âgée de plus de 40 ans et avoir au moins un enfant; ou 35 ans et au moins trois enfants; ou 30 ans et au moins cinq enfants; ou encore 25 ans et au moins six enfants.

En Amérique centrale, la stérilisation volontaire est légale partout, sauf au Nicaragua. Il y a peu de restrictions, excepté à Panama (5 enfants, conditions socio-économiques difficiles).

En Amérique du Sud, 5 pays sur 9 autorisent la stérilisation (Brésil, Colombie, Equateur, Guyane et Pérou). La loi impose également des restrictions dans certains de ces pays: en Colombie, être âgée de 35 ans et avoir plus de deux enfants, dont au moins un de chaque sexe; en Equateur, 25 ans et au moins trois enfants. Tous les pays pronatalistes (Argentine, Chili, Uruguay et Bolivie) interdisent la stérilisation volontaire.

Dans l'ensemble de l'Amérique latine, 4 millions de couples étaient stérilisés pour des motifs contraceptifs en 1978 (0,5 million en 1970)45/: 21.000 en Colombie (1977, 3.000 au Guatemala (1977), 55.000 au Mexique (1976), 70.000 à El Salvador (1977), etc.

44/ Christopher Tietze, "Induced Abortion", 1979, op.cit.

45/ C.P. Green, "Voluntary Sterilization : World's Leading Contraceptive Method", op.cit. et Jean-Paul Sardon, "La Stérilisation dans le monde, I et II, op.cit.

L'importance relative de la stérilisation parmi les autres moyens contraceptifs varie d'un pays à l'autre et à l'intérieur d'un même pays, d'une année à l'autre: ainsi à Costa Rica en 1976, 6,9 p. 100 des acceptants des services de planification familiale utilisaient la stérilisation (la proportion était de 1,1 en 1973); en Jamaïque, la progression a été constante, passant de 4,8 p. 100 en 1972 à 11,8 p. 100 en 1975; à Porto Rico, la proportion est de 16,9 p. 100 en 1975 et à El Salvador de 27,5 p. 100. En revanche à Panama, la proportion est tombée de 23,9 p. 100 en 1972 à 5,3 p. 100 en 1975.46/

Parmi les autres mesures légales qui peuvent avoir un effet significatif sur la fécondité, certains pays ont modifié l'âge minimum légal au mariage ou l'ont codifié: ainsi la Barbade a porté celui-ci à 16 ans pour les hommes et 14 ans pour les femmes en 1976.47/

Après avoir considéré comment les mesures d'ordre légal s'inscrivent dans la perspective parfois contradictoire de politiques pronatalistes ou antinatalistes, examinons maintenant les autres mesures mises en oeuvre par les gouvernements pour modifier ou maintenir le niveau de fécondité.

2. Mesures techniques

Parmi les pays antinatalistes de la région, certains mettent en oeuvre un éventail varié de mesures d'ordre technique. Un effort d'intégration des programmes de régulation des naissances est entrepris dans plusieurs pays, et comme dans les autres régions, c'est de plus en plus au ministère de la Santé qu'incombe la responsabilité de gérer et de diffuser les programmes. Le tableau 12 indique qu'à El Salvador par exemple, ce ministère reçoit 11 p. 100 du budget national, et que plus de 6 p. 100 de ce budget est consacré aux programmes de régulation des naissances (ce qui représente 0,7 p. 100 du budget national). En comparaison, la part du budget que reçoit le ministère de la Santé en République Dominicaine (pays satisfait du taux de fécondité) est supérieure à celle de El Salvador, mais la part consacrée aux programmes de régulation, bien inférieure (1,2 p. 100 seulement). Au Costa Rica également, toutes les activités des programmes de limitation des naissances ont été confiées à la Division de la santé maternelle et infantile du ministère de la Santé.48/ A Haïti, le Président Duvallier a déclaré (Avril 1979) que le gouvernement souhaitait des petites familles et que les programmes de régulation des naissances étaient une priorité du plan national de santé.49/ Au Mexique, cette intégration est

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46/ Jean-Paul Sardon, "La Stérilisation dans le monde, I et II",op.cit.

47/ "Age at Marriage and Fertility", Population Reports, op.cit.

48/ D.L. Nortman and E. Hofstatter, "Population and Family Planning Programs", op.cit.

49/ Idem.

un objectif du plan de développement (1977-1982): tous les services publics de santé doivent inclure les programmes de régulation des naissances dans leurs activités. Le gouvernement qui souhaite faciliter au public l'accès aux moyens modernes de contraception, encourage les communautés locales à participer activement aux programmes de régulation.50/ Le gouvernement s'efforce également d'introduire la pratique de la contraception dans certains groupes de la communauté: l'armée, les institutions gouvernementales et semi-gouvernementales, etc.

Comme autre mesure technique, plusieurs pays tentent de "démicaliser" la contraception et confient de plus en plus à du personnel paramédical, la responsabilité des services de régulation des naissances. Des sages-femmes, spécialement entraînées, sont utilisées comme agents des services au Mexique, Costa Rica, Haïti, El Salvador.51/

La distribution ou la vente des produits contraceptifs par l'intermédiaire de circuits non commerciaux et de circuits commerciaux modernes ou traditionnels constitue un autre axe d'intervention des gouvernements. Au Mexique, le gouvernement a entrepris une vaste campagne de commercialisation des contraceptifs, pour les rendre accessibles partout dans le pays et à prix peu élevé. Une flotte de camions assure la distribution dans les magasins de détails, tels que les self-services, les épiceries, les magasins d'Etat, les magasins généraux dans les campagnes, etc.52/

Des contraceptifs sont fournis aux militaires, aux travailleurs des chemins de fer, au personnel de la Commission fédérale d'électricité, de la Compagnie nationale des pétroles, etc.53/

La Colombie54/ présente également un bon exemple de la diversification des réseaux de distribution des produits contraceptifs; le ministère de la Santé et Profamilia, association privée de planification de la famille, se partagent 90 p. 100 des services de régulation des naissances et de la fourniture des contraceptifs; les médecins et le secteur commercial assurent le reste, particulièrement dans les centres urbains. Dès 1965, les contraceptifs étaient largement disponibles dans les villes et les régions de plantation de café.

50/ Family Planning in Mexico, "A Profile of the Development of Policies and Programmes", International Planned Parenthood Federation.

51/ "Traditional Midwives and Family Planning", Population Reports, op.cit.

52/ Family Planning in Mexico "A Profile of the Development of Policies and Programmes", op.cit.

53/ "National Experience in the Formulation and Implementation of Population Policy : Mexico", United Nations, op.cit.

54/ Dorothy L. Norman, "Factors influencing Government Provision of Family Planning Services", Population Council. Document non publié.

3. Mesures économiques d'incitation et de dissuasion

Les pays en développement pronatalistes encouragent la fécondité par des mesures d'incitation, sous forme d'avantages économiques directs et indirects.

En Argentine par exemple, les avantages directs consistent en l'attribution de prime au mariage, à la naissance des enfants (ou d'adoption d'un enfant). Des allocations familiales sont versées aux familles dont les enfants fréquentent l'école, jusqu'au niveau secondaire, et ces allocations sont modulées en fonction du nombre d'enfants (supplément à partir du troisième). Citons parmi les avantages indirects: facilités de logement pour les familles, crèches et jardins d'enfants pour les mères ayant un emploi, facilités dans les conditions de travail pour les rendre compatibles avec la maternité, etc.55/ Le Brésil, qui se déclare satisfait de son taux et qui désire officiellement le maintenir à son niveau, prend des mesures destinées à protéger le bien-être et la liberté individuels.56/ Le ministère de la Santé a mis au point un programme pour améliorer les conditions médicales des accouchements et des services de régulation des naissances ont été développés et intégrés dans les programmes de nutrition. Les moyens contraceptifs sont disponibles, mais sujets à contrôle (on peut se procurer des pilules pour une durée de un an sur prescription médicale.57/

Plusieurs pays antinatalistes de la région assurent la distribution gratuite des produits contraceptifs et subventionnent, en tout ou en partie, le coût des avortements et des stérilisations, s'ils sont légalement autorisés. Le tableau 13 fournit quelques indications sur ce type de mesures financières directes d'incitation, mesures qui peuvent être prises également par des pays satisfaits du taux, en vue d'assurer le bien-être individuel (cas de la Colombie, République Dominicaine et Guatemala, dans les pays pris en exemple). On note que l'Etat prend pratiquement à sa charge, les frais d'insertion du stérilet, de la distribution des pilules et des condoms. Comme nous l'avons mentionné précédemment, peu de pays de la région autorisent la stérilisation.

55/ "Population Policy Compendium, Argentina", situation as assessed in January 1979, op.cit.

56/ Il semble cependant que depuis peu, le gouvernement manifeste des inquiétudes concernant les effets d'une fécondité "globale" élevée, mais la position officielle est restée la même jusqu'à présent.

"Population Policy Briefs : Current Situation in Developing Countries and Selected Territories", 1979, ESA/P/WP/67, 28 May 1980; Prepared by the Population Division Department of International Economic and Social Affairs of the United Nations Secretariat.

57/ Dorothy L. Norman and Ellen Hofstatter, "Population and Family Planning Programs, a Compendium of Data through 1978", a Population Council Fact Book, 10th edition, the Population Council, New York.

4. Mesures psychologiques

Quelques gouvernements, dont le Mexique en particulier, ont mis sur pied des campagnes psychologiques de persuasion ainsi que des programmes d'éducation et d'information auprès des jeunes et des adultes, en vue de les motiver à avoir moins d'enfants. L'appel du gouvernement mexicain pour "une parenté responsable" traduit à la fois les préoccupations démographiques de l'Etat et oblige les parents à considérer leurs responsabilités d'éducateurs.58/ Un programme de formation et d'orientation en matière de régulation des naissances a été développé pour les médecins, sages-femmes, infirmières et personnel paramédical. Ce programme s'adresse également aux travailleurs sociaux, aux experts en développement communautaire, aux employés de l'administration, etc. Le ministère de l'Education est associé aux autres départements ministériels responsables de la campagne, et est chargé particulièrement de la préparation du matériel nécessaire. Il a aussi la responsabilité de préparer un programme spécial à l'intention des jeunes et qui sera diffusé dans le système formel d'éducation.

5. Action sur les déterminants socio-économiques de la fécondité

Relativement peu de pays de la région ont considéré de façon explicite les effets éventuels des interventions sur les déterminants socio-économiques de la fécondité: plusieurs pays ont mis en oeuvre des politiques en vue d'améliorer les conditions sanitaires, la nutrition et la santé en général; d'autres font porter leur effort dans le domaine de l'éducation et le développement rural; quelques-uns essaient également d'améliorer le statut de la femme (Mexique).59/ Cuba, pays actuellement satisfait de son taux, a axé essentiellement sa politique sur le développement des conditions sociales et économiques qui peuvent influencer les comportements procréateurs: amélioration des niveaux d'éducation (rendue obligatoire pour les enfants, par programmes spéciaux pour adultes); urbanisation des zones rurales par l'établissement de services sociaux et projets de développement; construction de petites communautés urbaines; réduction des disparités entre les revenus à la ville et à la campagne; efforts gouvernementaux pour améliorer le statut de la femme et augmenter sa participation dans l'économie, par des programmes d'éducation, la mobilisation politique et la participation volontaire, la légalisation du code de la famille, le libre accès aux moyens de régulation des naissances, et plus récemment par l'entrée des femmes dans la population active. A ces mesures, s'ajoute la mise en oeuvre d'un vaste programme gouvernemental dans le domaine de la santé, incluant une campagne nationale d'éducation sur les soins maternels et infantiles (l'aspect santé découlant de la régulation des naissances), et un accès plus facile aux moyens contraceptifs.60/

58/ Margaret Wolfson, "Changing Approaches to Population Problems",op.cit.

59/ Family Planning in Mexico, "A Profile of the Development of Policies and Programmes", op.cit.

60/ Paula E, Hollerbach, "Recent Trends in Fertility. Abortion and Contraception in Cuba", The Population Council, No. 61, September 1980.

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Le tableau 15 indique qu'aucun pays de la région n'a modifié sa perception depuis 1978. La situation est donc la suivante: 1 seul pays (Irak) souhaite un taux plus élevé; 2 pays (Bahrein et Jordanie) désirent un taux plus bas et les 9 autres pays se déclarent satisfaits du niveau actuel de la fécondité.

L'Irak et 5 pays satisfaits du taux mettent en oeuvre des politiques en vue de modifier ou de maintenir le niveau de la fécondité tandis que les 2 pays souhaitant un taux plus bas n'entendent pas intervenir actuellement. L'Irak est cependant satisfaite du taux d'accroissement mais en revanche, Qatar, Oman, Emirats Arabes Unis et Arabie Saoudite, tout en étant satisfaits du taux de fécondité, souhaitent un taux d'accroissement plus élevé.

1. Mesures légales

L'accès et la diffusion des moyens contraceptifs, permier type de mesures légales dont disposent les gouvernements, sont autorisés et soutenus directement par 4 pays de la région et indirectement par 2 (cf tableau 3). Parmi ces pays, 2 sont antinatalistes et 4 satisfaits du taux. L'Arabie Saoudite, qui est satisfaite de son taux, est le seul pays de la région à interdire l'accès aux moyens contraceptifs. Parmi les 5 autres pays qui l'autorisent mais n'apportent aucun soutien, l'Irak est pronataliste et les 4 autres, satisfaits du taux.

On voit donc que dans les pays de la CEAO, comme dans ceux de la CEA et de la CEPAL, les restrictions apportées à l'accès et à la diffusion des moyens contraceptifs sont utilisées comme mesure par les pays pronatalistes, alors que les pays antinatalistes autorisent et soutiennent l'utilisation des méthodes contraceptives. La moitié des pays satisfaits du taux apportent leur soutien à la diffusion des moyens contraceptifs tandis que l'autre moitié l'autorisent simplement.

L'avortement et la stérilisation sont peu répandus dans les pays de la CEAO: la loi religieuse islamique est en vigueur pratiquement partout et elle n'autorise l'avortement que si la vie de la mère est en danger (cf tableaux 4 et 5). En Jordanie, la loi civile autorise l'avortement pour risque à la santé de la mère. La stérilisation n'est pas défendue, mais les croyances religieuses s'opposent à son usage, sauf pour des raisons médicales ou de malformations héréditaires et autres du foetus. Au Liban, bien que la loi civile ne soit guère explicite, la stérilisation est encouragée par les associations de planification de la famille et pratiquée en fait "à la demande", mais la femme doit être âgée d'au moins 30 ans et avoir un minimum de 3 enfants.

Tableau 15. Changements dans les perceptions gouvernementales concernant le taux global de fécondité, juillet 1978 - juillet 1980

Pays situés dans la Région de la CEAO

	Perceptions gouvernementales concernant l'acceptabilité du taux actuel de fécondité et désir d'intervention en vue de le modifier						
	Taux non satisfaisants parce que trop bas: taux plus élevés souhaitables		Taux satisfaisants		Taux non satisfaisants parce que trop élevés: taux plus bas souhaitables		
	Intervention pour augmenter les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Mais mesures d'encouragement ou de dissuasion mises en oeuvre pour maintenir les taux	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention pour diminuer les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Total
	I	II	III	IV	V	VI	
Nombre de pays dans chaque catégorie en 1978	1	-	5	4	2	-	12
Changements dans les perceptions concernant l'acceptabilité du taux actuel et désir d'intervention en vue de le modifier durant la période 1978-1980		b					
Nombre de pays dans chaque catégorie en 1980	1	-	5	4	2	-	12

b) Pas de changement

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

2. Autres mesures

En dehors des mesures légales très restrictives, comme nous l'avons mentionné, peu de pays de la région mettent en oeuvre d'autres mesures. Il est vrai qu'un seul pays, l'Irak, souhaite un taux plus élevé et deux, un taux plus bas.

En Irak, des prestations familiales sont versées aux familles, particulièrement aux travailleurs: prime à la naissance et allocations familiales; congé de maternité de 10 semaines (salaire payé à 100 p. 100) et pouvant être étendu à 9 mois, en cas de complication (salaire payé à 75 p. 100) pour les femmes ayant un emploi. Des programmes d'éducation et d'information sont diffusés par l'intermédiaire des services de santé maternelle et infantile.61/

L'Arabie Saoudite, qui souhaite maintenir le niveau de la fécondité, prend des mesures du même ordre62/, tandis que la République Arabe Syrienne63/, qui désire contrôler l'évolution spontanée du taux, encourage l'espacement des naissances par des programmes d'éducation et d'information, le développement des services de santé maternelle et infantile et l'amélioration du statut de la femme (intégration professionnelle, etc.).

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En 1980, 2 pays de la région sur 30 souhaitent un taux plus élevé et 19, un taux plus bas tandis que les 9 autres sont satisfaits du taux. Aucun changement majeur de perception n'est intervenu depuis 1978 (cf tableau 16).

La République Démocratique Populaire Lao, pays pronataliste, met en oeuvre des politiques pour augmenter le taux64/ et la quasi totalité des pays souhaitant un taux plus bas (18 sur 19) pour le diminuer. La moitié des pays satisfaits prennent également des mesures, mais en vue de maintenir la fécondité à son niveau ou d'améliorer le bien-être individuel.

La République Démocratique Populaire Lao, qui souhaite un taux d'accroissement plus élevé, compte sur une fécondité plus élevée pour atteindre son objectif. Par contre, la Mongolie, République Populaire

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61/ "Population Policy Compendium": Irak", op.cit.

62/ "Population Policy Compendium : Saudi Arabia", op.cit.

63/ "Population Policy Compendium : Syrian Arab Republic", op.cit.

64/ Le Kampuchéa Démocratique souhaitait un taux plus élevé jusqu'en 1978.

Tableau 16. Changements dans les perceptions gouvernementales concernant le taux global de fécondité, juillet 1978 - juillet 1980

Pays situés dans la Région de la CESAP

	Perceptions gouvernementales concernant l'acceptabilité du taux actuel de fécondité et désir d'intervention en vue de le modifier						
	Taux non satisfaisants parce que trop bas: taux plus élevés souhaitables		Taux satisfaisants		Taux non satisfaisants parce que trop élevés: taux plus bas souhaitables		
	Intervention pour augmenter les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Mais mesures d'encouragement ou de dissuasion mises en oeuvre pour maintenir les taux	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention non appropriée. Mi mesures d'encouragement ou de dissuasion mises en oeuvre	Intervention pour diminuer les taux appropriée et mesures d'encouragement ou de dissuasion mises en oeuvre	Total
	I	II	III	IV	V	VI	
Nombre de pays dans chaque catégorie en 1978	2	-	3	8	1	16	30
Changements dans les perceptions concernant l'acceptabilité du taux actuel et désir d'intervention envue de le modifier durant la période 1978-1980	b	b		-Malaisie -Singapour	b		
	b	b	+Singapour +Malaisie +Kiribati a/		b	+Iles Salomon a/ +Tuvalu a/	
Nombre de pays dans chaque categorie en 1980	2	-	6	6	1	18	33

a/ Les pays soulignés sont devenus indépendants durant la période 1978-1980
b) Pas de changement
(+) Pays entrant dans cette catégorie
(-) Pays changeant de categorie

Source: Informations rassemblées à partir de la Quatrième Enquête sur la population des Nations unies de 1978 et de la Banque des données sur les politiques de population de la Division de la population

Démocratique de Corée, Bhoutan et Nauru sont satisfaits du taux de fécondité, mais souhaitent un taux d'accroissement plus élevé, les deux premiers comptant sur une baisse de la mortalité pour atteindre cet objectif, les deux autres sur la migration internationale.

1. Mesures légales

Le tableau 3 indique qu'en Asie, 26 gouvernements autorisent et soutiennent directement l'accès et la diffusion des moyens contraceptifs. Parmi ces pays 19 sont antinatalistes et 7 satisfaits du taux. Les deux seuls pays qui limitent l'accès sont les deux pays pronatalistes de la région. Les Maldives et la Malaisie, satisfaits du taux, autorisent l'usage des moyens contraceptifs, mais les gouvernements n'en soutiennent pas la diffusion. Comme dans les autres régions des pays en développement, l'accès aux méthodes contraceptives est déterminé par l'orientation des politiques gouvernementales pronatalistes ou antinatalistes.

Considérons maintenant les mesures légales concernant l'avortement et la stérilisation: parmi les pays en développement, c'est sans aucun doute dans la région de la CESAP que l'on trouve la plus grande proportion de pays à avoir libéralisé l'avortement et surtout la stérilisation volontaire.

Trois pays, la Chine, l'Inde et Singapour autorisent l'avortement "à la demande" (cf tableau 4). En Chine, l'avortement est encouragé et facilité par l'Etat et est largement pratiqué comme méthode de régulation des naissances. Après un avortement, une femme a droit à 14 jours de congé payé de maladie et à 30 jours, si l'avortement a lieu après trois mois de grossesse. La législation, qui date de 1979, est actuellement une des rares au monde à encourager l'avortement au-delà de trois mois de grossesse. En Inde, la loi autorise l'avortement de toute grossesse résultant de l'échec d'une méthode contraceptive masculine ou féminine (c'est pourquoi nous avons considéré l'avortement comme autorisé "à la demande").

Trois pays (République Démocratique de Corée, Iran (situation en 1978), et Fidji) autorisent l'avortement pour raisons socio-économiques plus ou moins largement interprétées.

Dix pays autorisent l'avortement pour préserver la santé mentale de la mère, mais l'interprétation donnée à cette disposition semble assez large.

Au Pakistan, Bangladesh et Indonésie, l'avortement n'a pas été libéralisé, bien que ces pays soient antinatalistes.

En Inde, comme à Singapour, le nombre d'avortements est en progression constante, mais, alors que dans le premier l'avortement reste une méthode relativement peu utilisée (en 1977, 278.000 avortements et un taux d'avor-

tement de 2,2 p. 1000 femmes (15-44 ans), dans le second, le taux d'avortement s'élève à 28,4 (en 1970 le taux était de 4,1).65/

En République de Corée, où cependant l'avortement n'a pas été libéralisé, le nombre d'interventions s'est élevé à plus de 330.000 en 1970, soit un taux d'avortement de 50,1 p. 1000 femmes (15-44 ans).66/

Comme nous l'avons mentionné, la stérilisation volontaire a été largement libéralisée en Asie: 9 pays l'autorisent "à la demande", 2 pour raisons socio-économiques et 4 pour motif de régulation des naissances (cf tableau 5). En Chine, la stérilisation est essentiellement considérée comme un moyen de régulation des naissances: elle est hautement encouragée par les autorités et autorisée sans aucune condition; toute une infrastructure médicale a été mise sur pied (unités mobiles, personnel paramédical) pour rendre la stérilisation accessible au plus grand nombre.67/

La République de Corée également, encourage largement la stérilisation comme méthode de régulation des naissances.68/

En Asie de l'Est, la stérilisation volontaire est légale en Malaisie, Philippines, Singapour et Thailande pour raisons socio-économiques et de contraception.

En Asie du Sud, elle est autorisée partout, sauf en Afghanistan et en Iran69/. Elle est autorisée aussi à Fidji. Dans plusieurs pays de cette région, non seulement la loi est très libérale, mais des mesures de persuasion et de dissuasion sont mises en oeuvre pour inciter les couples à se faire stériliser. Des programmes d'Etat, appuyés par de vastes campagnes d'information et de véritables stratégies d'action ont été mis sur pied, comme nous le verrons dans la suite.

On estimait en 1978 que 36 millions de couples étaient stérilisés en Chine (4 millions en 1970), 22 millions en Inde (7 millions en 1970) et 4 millions pour l'ensemble des autres pays asiatiques dont 530.000 en République de Corée, 405.000 au Bangladesh (1977), 90.000 au Philippines (1977), 42.000 en Indonésie (1977), 27.000 en Malaisie, 39.000 au Népal (1977), 48.000 à Singapour (1977), 122.000 au Sri Lanka (1976), 395.000 en Thailande (1977), etc.70/

65/ Christopher Tietze, "Induced Abortion", 1979, op.cit. and "Demographic Yearbook 1977 and 1978", United Nations, op.cit.

66/ Idem.

67/ "Population" China News Analysis, No. 1163, September 14, 1979.

68/ "Population Policy Compendium : Republic of Korea", United Nations, op.cit.

69/ Situation en 1978.

70/ Jean-Paul Sardon, "La stérilisation dans le monde", Population, op.cit.

La proportion d'acceptants de la stérilisation parmi les acceptants des services de planification familiale est plus élevée dans les pays asiatiques que partout ailleurs[71]: ainsi en 1976, cette proportion était de 0,5 p. 100 au Pakistan, 4,9 au Bangladesh, 65,1 en Inde, 5,2 en Malaisie, 9,7 au Népal, 7,4 aux Philippines, 25,3 à Singapour, 20 en Thailande, etc.

Selon les pays, l'importance relative de la stérilisation comme moyen contraceptif a varié: au Bangladesh, Sri Lanka, Thailande, la progression a été constante au cours des récentes années; en revanche, dans des pays comme l'Inde, Népal, la proportion a diminué pour reprendre ensuite depuis quelques années.

Tous les pays qui ont libéralisé l'avortement et surtout la stérilisation sont antinatalistes ou satisfaits du taux de fécondité. Dans les deux pays pronatalistes de la région, l'avortement et la stérilisation sont interdits ou l'information n'est pas disponible. Cependant quelques pays antinatalistes tels le Bangladesh, Indonésie et Pakistan n'ont pas libéralisé l'avortement.

Comme autre mesure légale, plusieurs pays de la région ont modifié ou légalisé l'âge minimum au mariage. Le Sri Lanka a porté cet âge à 18 ans pour les hommes, 16 ans pour les femmes en 1978, de même que le Népal en 1975[72]. Plus récemment, la Chine a proposé de porter cet âge minimum respectivement à 22 ans pour les femmes et 23 pour les hommes.

2. Mesures techniques

Considérons maintenant les mesures techniques mises en oeuvre par les pays antinatalistes et certains pays satisfaits du taux de fécondité, mais qui continuent à prendre des mesures pour le réduire davantage. C'est principalement dans le cadre des activités du ministère de la Santé que la plupart des pays intègrent leur programme de régulation des naissances, comme dans les autres régions en développement. Le tableau 12 indique, pour quelques pays de la région, la part du budget national consacrée à la santé et aux programmes de régulation des naissances. En Indonésie et République de Corée, le budget du ministère de la Santé représente une part modeste du budget national, mais près de 25 et 16 p. 100 respectivement de ce budget sont consacrés aux programmes de régulation des naissances. De façon générale, c'est aux services de santé maternelle et infantile que les ministères de la Santé font appel pour diffuser les programmes de régulation des naissances à travers le territoire et particulièrement en milieu rural.

71/ Jean-Paul Sardon, "La stérilisation dans le monde", Population, op.cit.

72/ "Age at Marriage and Fertility", Population Report, op.cit.

Des expériences nouvelles d'intégration des programmes de régulation des naissances dans d'autres services de santé, que les services de protection maternelle et infantile, et dans des projets ou programmes appartenant à d'autres ministères, que celui de la santé, sont aujourd'hui tentées dans quelques pays. On peut citer les expériences en cours en République de Corée, Philippines, Thailande, Indonésie et Malaisie où l'on essaie d'intégrer les programmes de régulation dans les services préventifs et curatifs des maladies parasitaires, fonctionnant dans les zones rurales[73]. Au Sri Lanka un projet associe les programmes à un plan d'assistance alimentaire et, en Inde, aux projets de développement rural intégré. Cette expérience indienne est certes très intéressante à suivre, car elle compte parmi les premières dans le genre. Comme le note B. Berelson, ce type d'approche "horizontal" repose plus sur une transformation de procédures et d'administration au niveau de la communauté de base que l'approche "vertical" qui aborde le problème à la fois par des programmes de limitation des naissances et des actions sectorielles indépendantes (éducation, industrialisation, etc.)[74]

Un autre moyen technique de plus en plus utilisé en vue d'améliorer l'offre des services de régulation des naissances, et par le fait même dans une certaine mesure, la demande des services, a consisté à décentraliser les programmes et à les réorienter en direction des communautés locales, villages, quartiers, ou de certains groupes de la communauté, associations, entreprises, etc. La Chine a poussé très loin ce type d'expérience[75]: la mise en oeuvre des mesures est décidée par le ministère de la Santé qui en assure la responsabilité d'ensemble; l'exécution est effectuée par un système d'unités administratives hiérarchisées où une délégation des responsabilités de fait d'un échelon à l'autre jusqu'au niveau des pouvoirs locaux. Les organes du Parti et des organisations à but humanitaire comme celle de la "Fédération des femmes" doublent le système administratif.

Un autre exemple est celui de l'Indonésie[76]: le gouvernement a donné à la population et à ses communautés (particulièrement les communautés très structurées connues sous le nom de banjar) la responsabilité et la mise en oeuvre des programmes, incluant les campagnes de motivation, le recrutement des couples aux programmes de régulation des naissances et la distribution des moyens contraceptifs. Les projets de développement locaux, qui sont de

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73/ Il s'agit d'un projet commun intitulé "The Joint Parasite Control/ Nutrition/Family Planning Project", lancé à l'initiative du "Japanese Organization for International Cooperation in Family Planning" et financé en partie par l'IPPF et la FNUAP.

74/ Bernard Berelson, W. Parker Mouldin and Sheldon J. Segal, "Population : Current Status and Policy Options", Center for Policy Studies, Working Paper No. 44, May 1979, The Population Council.

75/ Y.C. Yu, "The Population Policy in China", Population Studies, Vol. 33, No. 1, March 1979 and "Population" China News Analysis", op.cit.

76/ "Population Policy Compendium : Indonesia", United Nations, op.cit.

la responsabilité de divers ministères, sont associés à la réussite des objectifs fixés par le gouvernement en matière de fécondité.77/ Ces programmes ont été incorporés dans les plans de développement, connus sous le nom de Repelita I (1963-1974) et Repelita II (1975-1979). Les Philippines suivent une politique semblable et transfèrent la responsabilité des programmes de régulation des naissances des dispensaires aux communautés locales. Plusieurs pays utilisent également les entreprises industrielles pour diffuser la contraception (Inde, Philippines, République de Corée). Aux Philippines, les entreprises industrielles employant plus de 200 personnes sont requises par la loi d'inclure les moyens de régulation des naissances dans leurs services de santé. En République de Corée, les programmes de régulation sont associés aux systèmes d'assurance-santé que lancent les industries.

D'autres organisations sont aussi utilisées pour diffuser les programmes: groupes sportifs (Philippines), associations de jeunes (Inde), police frontalière (Thailande)78/, l'armée ainsi que le mouvement des nouveaux villages qui regroupe quelque 35.000 clubs de mères en République de Corée.79/

Un autre moyen d'action consiste à la "démicalisation" de la contraception. De très nombreux pays confient de plus en plus à du personnel non médical, particulièrement aux sages-femmes, la responsabilité des services de régulation des naissances. Ces programmes sont actuellement implantés au Pakistan, Bangladesh, Philippines, Indonésie, Thailande, Malaisie80/. Certains pays font aussi appel à des chefs de village, des instituteurs, des organisations féminines, etc. pour remplir les mêmes fonctions. Aux Philippines, c'est à un personnel paramédical qu'on fait appel pour la distribution des pilules et l'insertion des stérilets.

De nombreux pays également ont établi de vastes programmes de distribution ou de vente des produits contraceptifs par l'intermédiaire de circuits non commerciaux et de circuits commerciaux modernes ou traditionnels.

Ces expériences ne sont cependant pas sans présenter des risques, particulièrement avec la diffusion des contraceptifs à base hormonale.

77/ "Report of the Expert Group Meeting on Socio-Economic Measures Affecting Fertility Behaviour with Special Emphasis on Actionable Programmes", op.cit.

78/ Margaret Wolfson, "Changing Approaches to Population Problems", op.cit.

79/ "Population Policy Compendium : Republic of Korea", United Nations, to be published.

80/ "Traditional Midwives and Family Planning", op.cit.

Certains s'inquiètent de voir confier la responsabilité de distribuer des produits, dont les dangers potentiels ne sont pas nuls, à des gens sans formation médicale suffisante, qui sont incapables de réagir correctement si des effets secondaires se développent.81/

3. Mesures économiques d'incitation et de dissuasion

De nombreux gouvernements ont fait porter leurs efforts dans ce domaine et de nouvelles mesures sont mises en oeuvre constamment (Chine).

Parmi les pays pronatalistes, comme la République Démocratique Populaire du Lao ou la Mongolie, qui souhaitent maintenir le taux à son niveau, des mesures économiques d'incitation et de dissuasion ont été mises en oeuvre.

En Mongolie par exemple, un programme complet de mesures a été élaboré lors de la préparation du 5ème Plan de développement (1971-1975): parmi les mesures d'incitation, on citera un système d'allocations familiales très complet, des avantages variés comme la retraite à 50 ans pour les travailleuses, mères de 4 enfants et plus. Dans le 6ème Plan de développement (1976-1980), ces mesures ont été renforcées et des mesures nouvelles ont été ajoutées comme les congés de maternité d'une durée de six mois avec versement d'allocations représentant la moitié du salaire. Mais des mesures de dissuasion existent également: imposition à raison de 2 p. 100 par an du revenu des personnes non mariées à partir de 16 ans, et imposition des couples sans enfant.82/

Dans les pays antinatalistes, une première mesure d'incitation consiste en la fourniture de moyens contraceptifs. Le tableau 13 indique pour quelques pays les services contraceptifs qui sont offerts gratuitement ou fournis à coût réduit. On note que la plupart des pays offrent gratuitement l'insertion du stérilet ou la distribution de condoms. La stérilisation est souvent effectuée gratuitement tandis que les pilules sont vendues à prix très réduits. En plus de la gratuité ou des bas coûts des services, de nombreux pays offrent une prime financière aux acceptants de la contraception. Certains pays offrent également une prime financière aux "diffuseurs" des moyens de contraception et parfois même aux fournisseurs de produits contraceptifs (Inde, Pakistan).

Dans les nombreux pays qui ont décentralisé les programmes de régulation des naissances, les primes accordées par l'Etat aux personnes ou organismes qui diffusent les méthodes de contraception reviennent très souvent aux communautés locales à qui cette responsabilité a été confiée. Cette mesure s'applique aussi dans certains cas, pour la fourniture des moyens contraceptifs, lorsque des centres coopératifs de distribution sont établis à l'échelle locale.83/

81/ Dorothy L. Norman, "Factors Influencing Government Provision of Family Planning Services", Population Council. Document miméographié.

82/ "Population Policy Compendium : Mongolia", United Nations, op.cit.

83/ Margaret Wolfson, op.cit.

A ce type de récompense s'ajoutent des systèmes gradués d'incitation directe et indirecte, destinés à favoriser un certain type de comportement procréateur. Ces récompenses peuvent être d'ordre financier, en nature ou en bénéfices sociaux, attribuables immédiatement ou différées, si la famille a respecté les normes familiales prônées par le gouvernement. Présentons quelques exemples pour illustrer ces différents types de mesures. Au Sri Lanka, à l'occasion d'une campagne lancée en faveur de la stérilisarion masculine auprès des travailleurs des plantations de thé, des bénéfices accrus de maternité étaient offerts à ceux qui acceptaient de se faire stériliser après la naissance du deuxième ou du troisième enfant[34]. En République de Corée, les couples avec deux enfants reçoivent une priorité absolue dans l'obtention des logements neufs, construits par le gouvernement, si la femme est âgée de moins de 40 ans.[35]

Le versement des récompenses est parfois différé: l'Inde a créé un système d'épargne et de retraite en faveur des familles qui s'engagent à n'avoir qu'un nombre limité d'enfants. Les avantages ne sont perçus que si le nombre d'enfants n'a pas été dépassé.

Parallèlement à ces mesures d'incitation, certains gouvernements, particulièrement ceux des pays qui ont déjà atteint un stade intermédiaire de développement, recourent à des mesures de dissuasion. Essentiellement, ces mesures tendent à pénaliser financièrement ou socialement les familles dont le comportement procréateur diffère de celui souhaité par le gouvernement. En général, ces mesures portent sur les frais d'accouchement, les congés payés de maternité, les priorités d'obtention d'emploi, de logement, du choix d'école et surtout sur l'abattement d'impôts sur le revenu et les allocations familiales. Donnons encore quelques exemples pour illustrer ces mesures et leurs modalités d'application.

A Singapour, les frais d'accouchement dans les hôpitaux gouvernementaux sont croissants avec le rang de naissance de l'enfant; mais si la mère accepte de se faire stériliser après un accouchement, celui-ci est gratuit[36]. Le congé payé de maternité est également supprimé à la naissance du troisième enfant et aux naissances subséquentes. Aux Philippines, le congé payé de maternité n'est accordé que pour les quatre premiers accouchements. La priorité dans l'obtention des logements subsidiés par l'Etat, est refusée aux familles nombreuses, et si elles ont un logement, interdiction leur est faite de louer des chambres (Singapour).

34/ International Planned Parenthood Federation, "Report to Donors", October 1979.

35/ "The Role of Incentives in Family Planning Programme", op.cit.

36/ Peter S.J. Chen and James F. Fawcett, "Public Policy and Population Change in Singapour", The Population Council, New York.

En ce qui concerne les allègements fiscaux, l'abattement d'impôts sur le revenu est limité à deux enfants en République de Corée[37] et à quatre dépendants aux Philippines. En Chine, l'exemption est supprimée à partir de la naissance du quatrième enfant. Au Népal, une loi sur l'impôt sur le revenu a été votée en 1975: elle supprime l'abattement d'impôts sur le revenu basé sur le nombre d'enfants à charge[38]. Certains pays comme la Chine, ont pris des mesures plus rigoureuses encore pour amener les couples à se conformer aux normes fixées: la gratuité scolaire et médicale est supprimée pour le troisième enfant et le salaire de chef de ménage est réduit de 10 p. 100 jusqu'à ce que ce troisième enfant atteigne l'âge de 14 ans.[39]

On voit donc que ces mesures d'ordre économique, utilisées par les gouvernements pour inciter les parents à limiter leur descendance, représentent en fait un système mixte. Dans un premier temps, et aussi longtemps que les couples se conforment aux normes fixées, les mesures sont des incitations qui les récompensent. Dans un deuxième temps, quand les couples ont dépassé les normes fixées, ces mesures deviennent dissuasives et les pénalisent.

4. Mesures psychologiques

La plupart des gouvernements ont mis sur pied des campagnes psychologiques de persuasion, utilisant les moyens traditionnels et modernes d'information. De vastes programmes d'éducation ont également été lancés à l'adresse des adultes et des jeunes à travers les systèmes d'éducation formels et informels.

Ces campagnes d'information et d'éducation constituent en fait un élément fondamental de toute stratégie de régulation des naissances: les politiques gouvernementales ne seront suivies que quand les familles seront persuadées de leur bien-fondé; elles ne seront efficaces que quand les couples connaîtront les moyens d'éviter les naissances et où se procurer ces moyens. Les responsables des programmes de régulation des naissances l'ont bien compris et on a établi ainsi dans un programme-type[90], basé sur les programmes en vigueur dans 18 pays, que le poste "information et éducation" représentait 14 p. 100 de l'ensemble des dépenses budgétaires du programme (la fourniture des moyens contraceptifs représentant à elle seule 56 p. 100 du budget).

37/ "Population Policy Compendium : Republic of Korea", United Nations, op.cit.

38/ "Population Policy Compendium : Nepal", Situation as assessed in May 1979, op.cit.

39/ "Population, China New Analysis", op.cit.

90/ Dorothy L. Norman, Ellen Hofstatter, "Population and Family Planning Program", op.cit.

La Chine a entrepris une vaste campagne de mobilisation des masses. Des slogans, simples mais persuasifs, sont largement diffusés: "plus tard, plus longtemps et moins" qui résument toute la stratégie gouvernementale (mariage à âge plus élévé, intervalles entre les naissances plus longs, et moins d'enfants).91/

Aux Philippines, l'étude des problèmes de population est intégrée dans les programmes scolaires à tous les niveaux. L'information est diffusée dans de nombreux pays par l'intermédiaire des médias, des service de santé maternelle et infantile, des organisarions sociales et culturelles (principalement les organisations féminines), des communautés locales (chef de village, instituteurs, étudiants bénévoles) et des entreprises. Des équipes mobiles circulent de village en village, utilisant images, graphiques et moyens audio-visuels.92/

5. Actions sur les déterminants socio-économiques de la fécondité

Un dernier type de mesures consiste dans les interventions sur les déterminants socio-économiques de la fécondité. Certaines expériences nationales ont effectivement montré que l'amélioration des conditions de vie entraînait une diminution de la fécondité. Les succès les plus probants, dans les programmes de baisse de fécondité, ont été réalisés dans les pays qui se trouvaient déjà à un stade plus avancé de développement (Singapour par exemple). En revanche, dans les pays où le fossé entre la croissance de la population et le développement économique se creuse davantage, les gouvernements réalisent que les programmes de régulation des naissances, appliqués sans autres actions sur les déterminants de la fécondité, n'étaient pas suffisants. La déclaration du chef de la délégation indienne à la Conférence Mondiale de Bucarest exprimait bien le problème en déclarant: "notre véritable ennemi, c'est la pauvreté". En Inde, les réussites les plus probantes ont été réalisées dans certains états (Etat de Kerala par exemple) où le niveau d'éducation, le statut de la femme, la nutrition, l'égalité de la distribution des revenus étaient à un niveau de développement nettement supérieur à la moyenne nationale93/. Les Philippines orientent résolument leurs politiques en ce sens: tout en analysant le problème complexe des motivations de la fécondité et de ses déterminants, des politiques ont été mises en oeuvre (conjointement avec les programmes de régulation des naissances) pour réduire la mortalité et la morbidité. Ce n'est qu'une étape, car le gouvernement s'est fixé comme tâche d'agir sur la totalité des déterminants connus de la fécondité et non sur quelques-uns94/. Le Sri Lanka mène lui aussi une politique semblable.

91/ "Population", China New Analysis", op.cit.

92/ Margaret Wolfson, op.cit.

93/ Lester R. Brown, "Resource Trends and Population Policy : A Time for Reassessment", Worldwatch Paper No. 29, May 1979.

94/ Margaret Wolfson, op. cit.

Quelques pays de la région intègrent les programmes de régulation des naissances dans leur stratégie générale de développement. En République de Corée[12/] et en Thaïlande[13/] par exemple, un comité ou conseil de population a été créé à un niveau ministériel élevé, en vue de coordonner les politiques de population et de les intégrer dans les autres secteurs de la planification.

Dans les pays en développement qui désirent réduire leur fécondité, le débat porte moins aujourd'hui sur la légitimité des interventions de l'Etat ou même sur leur efficacité que sur leurs modalités et leur intensité. Depuis Bucarest, les programmes de régulation des naissances ont puisé une légitimité accrue dans le concept d'intégration qui, bien que vague, indiquait une direction essentielle d'action: les programmes de régulation des naissances, pour être acceptables et donc efficaces, devaient être conçus comme partie intégrante d'une stratégie d'ensemble d'amélioration du niveau de vie. Cette intégration semble être largement acquise au niveau des techniques visant à améliorer l'offre et la demande des services.

En revanche, la prise en compte de façon délibérée, dans les stratégies de développement, des effets démographiques de telle ou telle intervention macroéconomique ou mesure sociale ne révèle pas de changements marqués dans la pratique gouvernementale depuis Bucarest. Cependant, la création récente de plusieurs dizaines d'unités de population chargées d'intégrer processus démographiques et non démographiques au sein d'organismes de planification, devrait contribuer à améliorer à terme la situation actuelle.

C'est bien en définitive la multiplication des mesures économiques d'incitation et de dissuasion (principalement en Asie), associée à une amélioration des procédures de distribution des services de régulation des naissances (dans l'ensemble des pays antinatalistes), qui paraît être un des traits marquants des politiques antinatalistes des dernières années. Leur extension rapide n'en pose pas moins des problèmes financiers sérieux et la tentation est grande de recourir à des pressions plus ou moins fortes, comme complément d'abord, comme substitut ensuite, à ces moyens d'incitation économique coûteux. Ajoutons à ce propos que la plupart des mesures mentionnées précédemment peuvent prendre ou non un caractère coercitif (au sens large) suivant la façon dont elles sont appliquées. Les autorités chinoises, par exemple, sont bien conscientes de ce problème puisque, à l'occasion de la présentation du Sixième Plan Quinquennal de développement (1981-1985), elles ont insisté sur le fait que seuls la persuasion, le travail idéologique et politique doivent être mis en oeuvre pour appliquer les programmes de régulation des naissances, à l'exclusion des moyens coercitifs qui avaient été parfois employés.

12/ "Population Policy Compendium : Republic of Korea", United Nations, op.cit.

13/ "Population Policy Compendium : Thailand", United Nations, op.cit.

Cependant, nous avons vu dans ce chapitre qu'un nombre relativement restreint, mais significatif de pays en développement qui considèrent leur fécondité trop basse ou satisfaisante, ont adopté des politiques pour modifier les niveaux et les tendances de la fécondité: il s'agit en général, à quelques exceptions notables, de pays de petite taille, au début de leur transition démographique et ayant donc une mortalité élevée. Ils estiment que le faible volume de leur population actuelle est un obstacle majeur à la pleine utilisation de leurs ressources naturelles et constitue un danger potentiel pour leur sécurité. Pour la plupart (à l'exclusion de pays comme l'Argentine, la Mongolie ou la République démocratique de Corée), les politiques pronatalistes se réduisent, faute de ressources nationales et internationales, à des mesures d'ordre légal: l'accès aux différentes méthodes de contraception est souvent rendu difficile, l'avortement est plus ou moins interdit, l'âge au mariage est autorisé à un niveau relativement bas, etc. Certes, quelques mesures d'incitation économique comme des allocations familiales, des congés de maternité, des avantages fiscaux existent, mais souvent ne touchent qu'une fraction de la population, les salariés ou même parfois seuls les fonctionnaires. Elles semblent d'ailleurs être perçues davantage, dans le contexte socio-culturel des pays où elles sont appliquées, comme ayant une signification sociale que démographique.

Conclusion

La majorité des pays, aussi bien dans les régions développées que dans celles en développement, est confrontée aux problèmes d'une fécondité "globale" perçue trop basse ou trop élevée ou bien à ceux que pose l'évolution de la fécondité "individuelle", par le maintien ou l'amélioration du bien-être des familles.

Comment peut-on comparer les stratégies auxquelles ont recours ces différents groupes de pays?

Dans les pays développés, les mesures légales (accès aux moyens contraceptifs, avortement, stérilisation, âge au mariage) tendent à devenir indépendantes des objectifs de politique démographique (à l'exception des pays de l'Europe de l'Est). Ces mesures visent essentiellement à assurer le bien-être des individus et à leur permettre de contrôler en toute liberté leur fécondité.

Dans les pays en développement, au contraire, les mesures légales sont, en général, liées à des objectifs démographiques. Dans les pays pronatalistes et dans certains pays satisfaits de leur taux de fécondité, mais qui souhaitent le maintenir à son niveau, les dispositions sont dans l'ensemble relativement restrictives, par contre, dans les pays antinatalistes ou dans certains pays satisfaits de leur taux mais qui souhaitent le réduire encore, elles ont été beaucoup plus libéralisées. La libéralisation de la stérilisation semble avoir progressé plus rapidement que celle de l'avortement dans ceux-ci, tandis que dans les pays développés, les gouvernements se sont d'abord préoccupés de celle de l'avortement.

Parmi les mesures d'ordre technique que nous avons mentionnées tout au long de ce chapitre, le rôle donné aux communautés locales et à certains groupes de la communauté dans la diffusion et parfois dans la mise en oeuvre des moyens modernes de contraception, est apparu comme un des traits caractéristiques des nouvelles tendances dans l'organisation de ces services.

Cette tendance est en opposition avec ce qu'on observe dans les pays développés où le droit de l'individu à déterminer ses propres comportements procréateurs est quasi universellement reconnu.

Les mesures économiques d'incitation et de dissuasion sont un instrument qu'utilisent aussi bien les pays développés que les pays en développement. Chez les premiers, l'octroi de prestations familiales, d'abattement d'impôts sur le revenu, etc. permettent d'une part, d'encourager les familles à avoir un nombre d'enfants plus élevé et d'autre part, à donner aux familles une certaine compensation pour les frais d'élevage et d'éducation qu'entraîne la présence de l'enfant. Chez les seconds, si quelques pays pronatalistes ont recours à ce type de mesures, nous avons noté que la signification en était davantage sociale que démographique. En revanche, les pays en développement antinatalistes ont largement recours aux mesures d'incitation et de dissuasion d'ordre économique, pénalisant parfois sévèrement les couples qui ne se conforment pas aux normes de famille établies par le gouvernement.

Les mesures psychologiques d'information sont surtout mises en oeuvre dans les pays en développement, encore que dans les pays développés les médias privés et publics jouent un rôle important dans la diffusion de normes sociales dont l'influence sur la fécondité est sans doute considérable.

Enfin, si certaines interventions sur les déterminants socio-économiques de la fécondité revêtent une signification assez semblable dans les pays développés et en développement, d'autres revêtent une signification spécifique. Par exemple, l'amélioration de la condition féminine a, entre autres objectifs dans les pays en développement antinatalistes, de créer des conditions favorables à une baisse de la fécondité. Dans les pays développés pronatalistes, les mesures tendant à résoudre les contradictions entre maternité et activité, sont perçues comme influençant également la fécondité au travers d'une amélioration de la condition féminine. En revanche, l'éducation, la santé, l'emploi, etc. font partie dans ces pays, où l'Etat-Providence s'efforce de créer les conditions d'une société égalitarienne, de la catégorie des droits "acquis", non susceptibles de manipulation, alors que dans les pays en développement, ils peuvent être envisagés comme moyens indirects de modifier la fécondité dans le sens désiré, et donc sujets à diverses manipulations.

Chapter 20

INTERNATIONAL MIGRATION

Introduction

The movement of labour across national boundaries has assumed very large proportions in the last decade. At present, there are about 20 million migrants workers in the world, about 12 million of them from developing countries. The Middle East continues to be a major pole of attraction and is beginning to draw manpower from countries that formerly supplied labour migrants to Western Europe, as well as from a growing number of Asian countries. In recent years, there has been a tendency for governments to take increasingly active roles in overseeing recruitment and as recruiters themselves--both as a means of avoiding abuses and of increasing the export of manpower in conformity with labour-export strategies Among suppliers of labour to the Middle East, there has been a growing emphasis on the "project package" approach to manpower export, whereby Governments supply entire projects from design through execution. There remain, however, countries that engage solely in manpower export.

While there has been some concern among the labour-supplying countries with developing manpower markets outside the Middle East (in Southeast Asia, for example, as well as in parts of Latin America and sub-Saharan Africa), on the assumption that Middle East labour demands will be reduced in coming years, the flows to date have not seen significant.

In Asia, Africa and Latin America, intra-regional movements of labour tend to be spontaneous and often outside government control. The major flows continue to be toward traditional poles of attraction: in Latin America, toward Venezuela and Argentina in the Southern Cone; in sub-Saharan Africa, toward Gabon, Ivory Coast and South Africa; and in Southeast Asia, toward Singapore and Hong Kong. Much of the movement is of a circular or temporary nature, or involves border movements that are really inseparable from internal flows. In all regions, including the developed regions, it is probable that illegal flows have been increasing. Since an unknown but certainly a significant proportion of illegal migration consists of movement from poorer to richer countries, the phenomenon is likely to continue. What the long-term consequences will be--for the migrants, as well as for the sending and receiving countries--is imperfectly known. An obvious corollary is that the most appropriate policies and measures are equally unknown.

In Western Europe, the former chief destination of labour migrants, the closing of the door to the large-scale migration of foreign manpower remains in force. Migration streams are increasingly mature, consisting largely of dependants admitted for family reunification purposes. There is still some immigration to meet labour force needs, although these flows are closely monitored in order to prevent further "leakage" into permanence. While several Western European countries--notably Belgium, the Federal Republic of Germany, and Switzerland--passed

legislation within the past 2 years designed to improve the position, or facilitate the integration, of foreign workers and their dependants, there is still a wide gap in most countries between pronouncements of concern and actual policies. Other countries such as France have sought a continuing reduction in their stock of foreign workers, and have adopted legislation toward that end.

The former chief recipients of permanent immigration have adopted similar positions. In the past 2 years the United Kingdom has shifted to a position of restricting future immigration, particularly of Asians from Commonwealth countries. The United States of America, which is currently in the process of re-evaluating its immigration policy, is likely to make a number of minor adjustments such as abolishing its underused preference categories, although it appears to be moving in the direction of becoming more restrictive.

There are at present few countries at world level that desire permanent immigration. Several of these countries are not perceived as desirable migration destinations and have been unsuccessful in attracting migrants, while others have actually lost population through emigration. At the same time, few countries desire the permanent emigration of their nationals, although growing numbers desire emigration on fixed-term contracts. Virtually all countries affected by a brain or skill drain desire to reduce this flow. Although a wide variety of incentives and disincentives have been employed, few countries have been successful in repatriating skilled personnel.

The fact that a majority of countries desire neither immigration nor emigration is shown clearly in the summary tables on Governments' perceptions of the acceptability of current international immigration and emigration (Tables 1 and 3). More detailed tables on Governments' perceptions and policies, which include the names of individual countries, appear in the Annex on pages
As of 1980 only 6 countries with significant immigration consider it to be too low, as shown in Table 1, while four additional countries, in which immigration is not significant, desire greater immigration. On the other hand, 21 countries with significant immigration consider it to be too high.

Examining the policies which have been adopted with respect to immigration, which are shown in Table 2, nine countries have policies designed to achieve a higher rate of immigration; 17 countries with significant immigration have a policy to maintaining the current rate, subject to strict control; finally, 25 countries with significant immigration have adopted policies to curb immigration in the near future, maintaining the already established immigrant population.

As shown in Table 3, while 25 countries consider emigration to be too high, only 6 countries with significant emigration consider it to be too low. Three additional countries in which emigration is not significant desire greater emigration.

As shown in Table 4, with respect to emigration policies, 6 countries have adopted policies to achieve a higher rate; 28 countries with significant emigration have a policy of maintaining the current rate; finally, 26 countries with significant emigration have a policy of curbing emigration in the future.

Before beginning the following discussion of international migration policies at world level, which is organized according to the 24 sub-regions commonly employed by the United Nations Population Division, it is necessary to deal briefly with the problem of classifying migrants. In the present text, migrants have been grouped into one of four general categories: permanent, temporary, illegal, or refugees. For purposes of analysis, the first category generally refers to the more traditional type of immigration, involving the permanent immigration of persons with needed skills and a family ties to the receiving country. The second category, that of "temporary" migration refers to various types of labour migration, along a continuum from seasonal migration or border community to movements that in effect become permanent as has commonly occurred with large numbers of "guest-workers" in Western Europe. A third category, that of illegal migration, is essentially a sub-category of the third, since illegal migrants are typically labour migrants. The greatest number, however, fall somewhere in between, and under current international law it is the prerogative of the receiving country to grant or to deny asylum.

In employing the four categories of migrants throughout the present text, it is important to note that the categories sometimes overlap, both as a result of the lack of a standardized definition and of deliberate Government policy. Finally, it is important to note that while the various categories of migrants are treated separately in the present text, it is often the total volume of migration that affects Governments' perceptions of international migration and related policies.

E/A

Eastern Africa

One of the major refugee situations among many in the sub-region has resulted from continuing conflict between Ethiopia and Somalia. A number of countries have been affected. For example, the presence of an estimated 25,000 refugees from Ethiopia has placed a severe strain on Djibouti's economy since the country is arid, with inadequate domestic food production, and there is little likelihood that these refugees will be repatriated soon.

The major brunt of the war between Ethiopia and Somalia has been borne by Somalia, whose refugee population has increased its total population size by about one-third. As of spring 1980 Somalia was hosting more than 1.3 million refugees. Of that number some 750,000 were living in makeshift caps, with the remainder living among the local population. A serious problem is that many of the refugees have nomadic lifestyles and are not used to living in large groups; in addition, about 90 per cent of the refugees are women and children under 15 years of age. Although it has been a major producer of refugees, Ethiopia has in turn provided refuge to some 11,000 refugees, mostly from southern Sudan. The country's major problem, however, is the more than 2 million displaced persons within its borders.

In addition to the countries affected by the Ogaden conflict, many countries in the sub-region have granted asylum to large numbers of refugees. For example, Burundi has been assisting some 50,000 refugees from neighbouring countries, encouraging those without skills to move to designated rural settlements. Similarly, the United Republic of Tanzania, has provided assistance to large numbers of refugees from various countries in Southern Africa. A number of Tanzania's refugee settlements have become self-reliant communities, producing their own food and selling cash crops sufficient to meet their other expenses. In some cases, these refugee settlements have already been passed over to the Government for normal administration, on the same terms as the country's other villages and development schemes.

While Tanzania has been relatively successful in its refugee resettlement, many countries have experienced serious problems. In the case of Zambia, for example, the closing of its borders and the cutting off of main travel routes did not stop a steady stream of refugees. Although large numbers of Zimbabweans have begun to be repatriated, some 32,000 remained in Zambia as of May 1980. The drain on Zambian revenues caused by sheltering and feeding these refugees has become even more acute

as recurring drought has depleted food supplies.

Several countries in Eastern Africa have had recent successful experiences with repatriation. For example, with financial assistance from UNHCR, Uganda has begun to resettle large numbers of returning refugees and displaced persons, including thousands of Rwandans and Zairese who had previously lived in Uganda. A large flow of Ugandans may be expected to be repatriated, since the Government of Kenya revoked the refugee status of Ugandans living in that country, giving them until March 1980 to return. Similarly, the newest African nation, Zimbabwe, is well on its way to resettling its refugees. When its guerrilla war ended, about 500,000 persons held in "protected villages" by the country's former rulers became free to move. Of the some 200,000 who fled to Botswana, Mozambique and Zambia, about 35,000 returned to Zimbabwe to vote in the February 1980 elections. In a second phase, over 5,000 persons were repatriated from Mozambique in May 1980, while mothers and children and other vulnerable groups were air-lifted to Zimbabwe from Zambia. In a reverse flow, many of Zimbabwe's white citizens emigrated to South Africa in 1980, as well as to Australia and to the United Kingdom. A country that would like to encourage selective repatriation is Mozambique. In March 1980 the President delivered a plea for former Portuguese settlers living in other African countries to return to Mozambique, promising them special business incentives upon their repatriation.

Finally, Rwanda is somewhat unique among countries in the sub-region in that it has an explicit policy to promote the emigration of its nationals. As reported in its reply to the Fourth Population Inquiry in 1978, the Government desired to increase emigration as a means of "reducing demographic pressure on the land and of improving the well-being of the country's population". At that time it was reported to be exploring the possibility of bi-lateral accords with potential receiving countries. Recently, there have been reports that Rwanda may cooperate with Tanzania in a scheme to send Rwandese emigrants to populate the new capital city of Dodoma.

In addition to its policy of encouraging emigration, Rwanda has been a producer of refugees, primarily the minority Tutsi. By 1978 there were some 175,000 refugees living outside Rwanda, with considerable year to year movement back and forth.

Middle Africa

As is the case in Eastern Africa, refugees pose a serious problem for many of the countries in Middle Africa. In Gabon, formerly a major importer of contract labour, refugee pressures have contributed to the Governments's policy shift on immigration. While the Government reported in its 1978 reply to the Fourth Inquiry that it desired to maintain rather

than to increase immigration, due largely to an influx of refugees, it now desires to decrease the rate. In mid-1979 the Government reported that Gabonese nationals would receive priority in employment, noting that, without the large number of foreigners presently in Gabon, there would be no problem of unemployment among Gabonese. It further announced that the governments of those countries sending labour migrants to Gabon would be asked to assist in reducing these flows. Finally, the Government reported that a census would be taken of all foreigners in the country, and those whose situation was irregular would be repatriated to their respective countries.

The refugee movement of longest standing in the sub-region involves Equatorial Guinea, approximately one-third of whose population may have taken refugee in neighbouring countries, as well as in Spain, during the 1970s. Although there was a change of government in 1979, it is not yet known whether the new administration will encourage repatriation on any significant scale.

A more recent exodus occurred in 1979 in the wake of Chad's violent civil war, when some 100,000 refugees sought asylum in Cameroon. These refugees present a particularly serious problem , since they are concentrated in the northern province, which is one of Cameroon's poorest, and it is not yet known whether the movement will be of temporary or more permanent duration. In addition to providing emergency assistance to the Chadian refugee population, UNHCR has been assisting Cameroon with an information campaign aimed at encouraging the repatriation of refugees from Equatorial Guinea.

Another country in the sub-region--Zaire--is one of the major refugee-receiving countries on the African continent. The estimated 172,000 refugees living in Zaire as of 1979 were primarily nationals of Angola, the Angolan province of Cabinda, Uganda and Burundi. Although Zaire has generated sizeable refugee flows in the past, a large scale repatriation of Zairian refugees from Angola and other neighbouring African countries followed the Zairian Government's proclamation of a general amnesty in June 1978. During the year-long duration of the amnesty, some 120,000 to 150,000 Zairian refugees returned under UNHCR auspices from Angola, making it one of the largest organized border crossings in recent African history.

Finally, Angola has received some 20,000 to 30,000 refugees from northern Namibia (although it is not known how many of these "refugees" are non-combattants), and it has been the source of even larger flows. A large proportion of Zaire's 172,000 refugee are from Angola, as well as from Cabinda province. To date, however, Angola has shown no willingness to proclaim a general amnesty.

Northern Africa

The Libyan Arab Jamahiriya remains the major labour-importing country in Northern Africa. Increasing numbers of Egyptians and Tunisians have migrated there in recent years, as well as a wide range of other nationalities, although there is evidence that the Government has been applying pressure on foreigners in the managerial ranks, hoping that they will depart. Bilateral agreements have been increasingly important in regulating migration to the Libyan Arab Jamahiriya. The Libyan-Syrian agreement is of particular importance, although bilateral agreements have also been used to obtain labour supplies from non-Arab countries, including Bulgaria, Romania and Yugoslavia. In addition to these organized flows resulting from bilateral agreements, the Libyan Arab Jamahiriya has received large numbers of illegal migrants, particularly accross the Egyptian-Libyan border.

On the sypply side, Egypt remains one of the major exporters of labour to the Arab world. The Government views emigration as a positive benefit to the economy, and Ministry of Planning officials estimate that the number of Egyptians working abroad will increase to approximately one million by 1986. The Libyan Arab Jamahiriya and Saudi Arabia absorb over two-thirds of these Egyptian workers, while the other important receiving countries are Kuwait, Algeria, the United Arab Emirates and the Yemen Arab Republic.

Jordan is a country in which the numbers of Egyptians (and Syrians) have recently increased, due largely to a process of replacement migration, in which foreign workers have been brought in to offset the shortfall of labour resulting from the departure of Jordanians. Although Egypt as yet has no official migration policy, a number of measures have had the effect of increasing emigration. These include new import regulations and the creation of brokerage agencies that operate not only as facilitators of migration but also as active agents for influencing individuals to migrate.

Algeria, formerly one of the major suppliers of labour to France, now sends migrants to new destinations in the Middle East. Although there is no question of the Government's renewing labour emigration to France, the unprepared repatriation of hundreds of thousands of its nationals is considered to be an equally unacceptable policy alternative by Algeria. Consequently, the Government of Algeria strongly protested the French Secretary of Immigration's announcement that some 300,000 Algerian work permits--due to expire at the end of the 10-year period set out by a 1968 labour agreement--would not be renewed. Algeria has been urging France to extend those work permits that are due to expire in 1980 by at least one year, enabling Algeria to work out plans for the integration of returning migrants, a programme in which it feels the Government of France should participate.

Tunisia has faced problems similar to those of Algeria, although it has been somewhat more successful in channelling migrants to new destinations. Since the mid-1970s, various Middle Eastern countries, rather than France, have been the chief destinations of Tunisian labour migrants. An estimated 2 per cent of the Tunisian labour force is presently employed abroad, chiefly in the Libyan Arab Jamahiriya, and remittances have become a significant source of income for the Tunisian economy. The situation may change, however, since some 800 Tunisian migrant workers were expelled from the Libyan Arab Jamahiriya in early 1980 and a systematic round-up of Tunisian workers was reported, largely as a result of deteriorating relations between the two countries.

In contrast to those countries that primarily export temporary labour, the situation of Sudan is somewhat more complex. On the one hand, the emigration of a significant proportion of the country's modern sector labour force to the Libyan Arab Jamahiriya and Saudi Arabia has led to growing government concern. An additional concern has been an increase in illegal emigration; it has been estimated, for example, that as many as 70 per cent of the Sudanese labourers in Saudi Arabia during 1977/78 were employed on an illegal basis. On the other hand, in addition to a continuing influx of pilgrims, who are significant in Sudan's urban and modern sector agricultural labour force, migrant workers from Chad and from across Sudan's southern borders have enlarged its domestic labour market. This situation has been further complicated by a recent massive influx of refugees. As the country on the African continent with the second largest refugee population (the first is Somalia), Sudan has an estimated 340,000 to 350,000 refugees, with the largest numbers from Ethiopia and Uganda, and smaller numbers from Zaire and Chad. Although Sudan has its own unemployment problems, some 80,000 refugees from rural areas have been given work on agricultural schemes or with Sudanese tenant farmers. About half of the refugees are from urban areas, however, and have settled in Khartoum and the main towns, causing numerous problems in these areas.

Since the partition of the Spanish Sahara, large numbers of refugees have been generated by continued fighting. Controversy exists over the size of the Western Saharan population and the number of Saharan refugees. A majority of the refugees have sought asylum in Algeria. There is no consensus about their numbers, however, and estimates range from as low as 17,000 to as high as 120,000.

Southern Africa

The countries of Botswana, Lesotho and Swaziland continue in their roles as satellites, supplying manpower for the South African mines. Although the numbers of migrants have fallen off in recent years, ILO

estimates that some 21,000 Botswana and 10,000 Swazi nationals were employed in South Africa as of 1978. Lesotho, the poorest and most vulnerable of the countries dependant on the South African economy, had over 97,000 workers--50 per cent of its male and 10 per cent of its female labour force--employed in South Africa as of 1978. Government projections have estimated an increase in the "absent population" to some 180,000 workers by 1985.

With its economy continuing to expand, South Africa not only requires a continuing inflow of unskilled workers, but also desires increased immigration of skilled personnel. In early 1980 the Government announced a new policy designed to compensate for the shortage of artisans in all sectors of the economy. According to the new policy, which involves easing restrictions on overseas recruiting and assisting employers who are seeking workers abroad, artisans will be allowed to enter South Africa without firm job offers, a decision that is a reversal of previous policy. In addition, immigration procedures will be streamlined, an advertising campaign begun, and the Government's allowance toward the costs of passage of approved immigrants will be increased to 80 per cent as of April 1980.

With respect to the refugee situation, thousands of refugees have fled from Namibia in recent years in reaction to security measures imposed by South African forces operating in the territory. (For example, as many as 50,000 Namibians were ordered removed from "prohibited areas" along the 1,000 mile border with Angola). On the other hand, due largely to its political neutrality and central location, Botswana has served as a place of asylum for refugees and political exiles from Angola, South Africa and Zimbabwe. Since Botswana does not have sufficient agricultural land to allow large numbers of these refugees to settle, it serves primarily as a country of transit. In addition to many hundreds of registered refugees, Lesotho and Swaziland have large numbers of unregistered refugee students from South Africa, although the latter country is not currently a major source of refugees.

Western Africa

Although data for the sub-region are extremely imprecise, it would appear that current international migration flows correspond roughly to those of the recent past. The Ivory Coast continues to be the principal labour-importing country. According to the 1975 census there were 1.4 million foreign nationals in the country, of whom 719,000 were economically active, and who made up about 26 per cent of the total economically active population. Although the Government's policy of "ivorisation"--that is, filling managerial positions with Ivory Coast nationals--is still in effect, there has not been a significant reduction in the number of skilled personnel from overseas.

Several other countries in the sub-region continue to serve as lesser poles of attraction for foreign workers. For example, as of 1975 total immigrant labour in Ghana was estimated at 224,000, coming primarily from Togo, Upper Volta and Nigeria. The most recent estimate of foreign nationals in Senegal was 355,000 (c.1976), of whom 157,000 were economically active. Of this total, 51,000 were from outside Africa, with the remainder from within the region--namely, Guinea, Guinea-Bissau, the Gambia, and Upper Volta.

In recent years Beninese nationals have migrated in large numbers to Gabon, attracted by its expanding economy. This situation may be changing, however, since Gabon expelled some 10,000 Beninese workers in 1978, following a dispute between the two countries. Similarly, Upper Volta suspended its labour agreement with Gabon in 1977, although its nationals continue to migrate in large numbers to the Ivory Coast.

The sub-region of Western Africa has been less affected by refugee movements than the other African regions. At various regional meetings, such as the 1979 Arusha Conference, African Governments have emphasized the need for "burden sharing" involving countries from these less-affected areas. A formal mechanism, however, has not yet been set up. Ghana's representative at the Arusha Conference reported that his Government had invited refugees from other sub-regions, but that the response to the offer had not been encouraging.

Other refugee situations remain unresolved. Large numbers of refugees from the Western Sahara remain in camps in Algeria. Although there have been proposals for some arrangements recognizing POLISARIO autonomy in the Mauritanian third of the Western Sahara, or a POLISARIO mini-state in this area, the POLISARIO continues to demand full independence for the entire Western Sahara and the return of the refugees to their land.

Finally, although the Government of Guinea desires to increase its population growth, estimates of the number of Guinean exiles living abroad--chiefly in Senegal, the Ivory Coast and France--have been as high as one million, or nearly one-quarter of the Guinean population. In mid-1977 the President announced a general amnesty for all Guineans living abroad, as well as a number of incentive measures for the repatriation of students, intellectuals and entrepreneurs. An estimated 20,000 to 30,000 exiles have returned to Guinea since the amnesty, although several hundred thousand still remain abroad.

ECE

Eastern Europe

In accordance with the COMECON manpower cooperation (1971), the "mutual contractual exchange of manpower"--i.e. the mutual transfer of labour in specified economic fields for turning out production for the common benefit--continues to occur.

Although there are no official statistics regarding labour migration in the Eastern European countries, it is known that a majority of foreign workers--chiefly from Poland, Czechoslovakia, Bulgaria and Romania--are employed in the German Democratic Republic, a country that also receives daily commuters from across the Polish border. Czechoslovakia receives the second largest number of foreign workers, mainly from Poland and Yugoslavia.

All of the Eastern European countries continue to send and to receive small contingents of specialized workers. Bulgaria has sent small number of specialists to other COMECON countries and has brought in Yugoslav construction workers on fixed-term contracts. Since 1972, with contracts extended up to 1975 and again up to 1980, Hungary has been sending some 3,000 technicians and engineers per annum to work on 2-3 year contracts in various industrial establishments in the German Democratic Republic; in turn, Hungary has been receiving smaller numbers of specialized workers from the GDR and Romania. Poland has been sending large numbers of workers to Czechoslovakia and the German Democratic Republic, as well as to the Soviet Union, under different COMECON joint project obligations, in addition to the thousands of its nationals who commute daily across the border to the GDR. Romania, which has sent specialists in recent years to the Soviet Union, Bulgaria and Hungary to work on various joint COMECON projects, has received workers from the German Democratic Republic, Czechoslovakia and the Soviet Union. Apart from the mutual transfer of specialized labour, the governments of the Eastern European countries have adopted a considerable range of policies affecting emigration. On the one hand, Hungary has adopted rather flexible emigration and travel regulations. It is estimated that some 90 per cent of all applicants are granted permission to emigrate. Most cases involve family reunification and, despite laws restricting emigration to persons over age 55, a large degree of tolerance has been practiced. At the other extreme, the German Democratic Republic has made a thorough and methodical effort to limit emigration--as shown by a wide variety of travel restrictions, as well as by its efforts to build a strong sense of national identity. Emigration for the purpose of family reunification does occur, however, and involves the average annual emigration of some 10,000 GDR nationals to the Federal Republic of Germany.

The emigration policies of the other Eastern European countries fall somewhere in between those of Hungary and the German Democratic Republic. Although the Government of Bulgaria generally discourages emigration, it has accorded some recognition of the right of family reunification, as provided for under the Helsinki Accords (1975). In recent years, Bulgarian refugees, who are mostly young people and members of the country's Turkish Muslim minority, have sought asylum in the Federal Republic of Germany, the United States of America and Turkey. Czechoslovak refugees include a continuing flow of ethnic Germans to the Federal Republic of Germany, as well as persons leaving under the family reunification provisions of the Helsinki Accords. Poland's laws restrict emigration, which has declined since the mid-1960s and which now remains lower than before the signing of the Helsinki Accords. The Government denies many applications for exit visas, even for the purpose of family reunification, although a significant flow of ethnic Germans continues to depart for the Federal Republic of Germany, according to provisions of the Helsinki Accords. Finally, many of Romania's Jewish nationals have left that country in recent years, while its ethnic German minority has been emigrating to the Federal Republic of Germany at a rate of about 10,000 persons per annum.

Northern Europe

With the exception of the United Kingdom, which now considers immigration to be too high, there has been little change in the perceptions and policies of the Northern European countries. Denmark has had continuing net emigration in recent years, partly as a result of its policy of allowing immigration for the purpose of family reunion. Outward movement from Finland decreased by some 3,000 persons during 1978, while inward movement remained virtually stable. Although Sweden remains the first destination for Finnish migrants, there has been concern among both the Finnish and Swedish authorities at the increasing proportion of spontaneous migration--i.e., migration not channelled through the employment services of the two countries, as envisages in the original Nordic Common Labour Market Agreement. Norway's restrictions on immigration are still in effect, except for inhabitants of the other Nordic countries. In recent years, Norway has had a slight annual net influx; however, while Norway's net immigration from other European countries has increased, flows from various Asian countries have decreased considerably.

Although no major policy changes have taken place in Sweden, a number of measures have been taken to enforce immigration control, improve cooperation with sending countries, and promote the integration of foreign workers. Although Sweden's policy requires that all non-Nordic entrants be in possession of residence and, if appropriate, work permits before arrival in Sweden, only about 20 per cent have complied with this provision, with the remainder having been "exceptionally" admitted. The Parliamentary

Committe on Aliens Legislation recently proposed that these regulations should henceforth be firmly applied. Since Sweden's policy is designed to promote the use of all groups within the potential domestic labour force--including resident foreigners--as a means of requiring as little new immigration as possible, the Government has been concerned by the increasing proportion of immigration from Finland that is not channelled through the Employment Services of the two countries.

Although the United Kingdom has been a net exporter of population in recent years, the Government's current policy is aimed at curbing future immigration from Commonwealth countries. Legislation that was proposed in late 1979 would restrict most future immigration to the wives and children of male heads of families who were legally settled in Britain. The objectives of this legislation are to achieve a reduction of some 1,500 to 2,000 in annual immigration into Britain--out of a total immigration of some 70,000. Immigration has already been sharply curtailed over the past few years and Britain now experiences a net outflow of 5,500 emigrants per year, as well as a zero rate of natural increase.

On the issue of refugee resettlement, Denmark, Finland, Norway and Sweden have been among the highest contributors to UNHCR on a per capita basis. All of the countries have resettled small numbers of Indochinese refugees, with Sweden accepting those who are physically handicapped. Although the United Kingdom has a stock of some 153,000 refugees, it announced at the 1979 Geneva conference that it would take 10,000 additional Indochinese refugees. In general, however, British authorities consider that they should give priority to present and future refugees from traditional Commonwealth areas.

Southern Europe

As countries that were among the major suppliers of temporary "guest-workers" to Western Europe, the countries in Southern Europe have received a continuing flow of return migrants and now have a positive net migration balance. Although most governments in the sub-region have encouraged return migration, Malta continues to discourage returnees, since an influx of predominantly working-age population would cause further problems for its already strained labour market. At the same time, however, the Government has made various efforts--such as employing some 8,000 persons in its Emergency Labour Corps--to prevent high unemployment from being translated into higher emigration.

In recent years Greece has had a positive net migration balance, resulting from the return movement of former labour migrants, and from its policy of allowing the repatriation of ethnic Greeks. The trend in Italy has been largely similar. Since 1974 Italy has had a net migration gain, reflecting an excess of return migrants over emigrants, although the positive net migration balance conceals a considerable flow of migrant

workers that seems to have increased in recent years. Italy now sends a significant volume of emigrants to new destinations in Africa, Asia and Latin America, as a result of growing activity of Italian firms in these regions. At the same time, Italy receives significant numbers of illegal migrants from various Asian and North African countries, who serve essentially as replacement migrants.

In the case of Portugal, official emigration figures showed a rise of nearly 10 per cent in 1978 in total departures, largely as a result of movement to new destinations in Africa, Asia and the Middle East. There has been a marked increase in the numbers of Portuguese workers on fixed-term contracts heading to such oil-producing countries as Algeria, Libya and Iraq. Emigration to certain traditional destinations such as France and Germany has shown a high proportion of females in recent years, indicating the importance of family reunion in movement towards these countries.

Although Spain has received a continuing flow of return migrants, large numbers of its nationals remain abroad. The number of Spaniards residing in other European countries was approximately 959,000 as of 1978, of which 477,700 were in the active population. In addition, some 1.7 million Spaniards were resident in non-European countries, primarily in the Americas. The Government continues to promote overseas employment. Assisted emigration to various overseas countries increased by nearly 14 per cent during 1978, of which 35.2 per cent went to Venezuela. Employment offers from abroad totalled nearly 150,000 in 1978, of which a majority were from Europe, with some 117,000 from France alone. (Most of the offers from France were for seasonal workers, however, and mainly for nominated candidates known to the employer). The 50,000 returns from European countries in 1978 represented a drop of some 20 per cent over the previous year.

Yugoslavia has been affected by a similar return migration flow, although the net drop of 10,000 workers (32,000 outward and 42,000 inward) in Yugoslavia's migration balance during 1978 was probably compensated by a similar increase in the numbers of family members emigrating. This would leave the total number of Yugoslav citizens in European countries at nearly 1.1 million, of which 695,000 were employed. In addition, there were an estimated 348,000 Yugoslav migrants in various non-European countries, as well as some 13,000 workers employed abroad by various Yugoslav enterprises, mainly in building, contracting and dockwork. Although discussion of the subject continues in national, regional and local political circles, few concrete programmes exist for the employment of returned Yugoslav migrants. In particular, the Federal Law on the acquisition and utilisation of foreign funds for the expansion of such employment remained inoperative throughout 1978.

The countries in Southern Europe have been relatively less affected than Northern and Western Europe by refugee flows in the past two years. Italy continues to be a country of transit for Eastern European refugees. Spain has accepted some 100,000 Latin American political refugees over the years, including many Cubans, and it agreed to accept several hundred more Cubans during 1980. Portugal set up a programme for the repatriation of former Angolan residents in 1978, although it is not yet certain at what rate these return migrants will be absorbed. It has accepted small numbers of refugees from East Timor but has been unable to accept all those who claim Portuguese citizenship, due to the continuing presence of large numbers of refugees from its former African colonies.

Western Europe

The situation of former "guest workers" in Western Europe has changed little in the past 2 years. The existing stock of foreign workers has not been greatly reduced, while immigration that permits the reunion of families of foreign workers continues in a number of countries. A major issue requiring resolution is that of the integration of foreign workers and their families. Toward this end, Belgium and the Federal Republic of Germany passed legislation in 1979 that will facilitate the integration of foreign workers, while Switzerland revised its nationality laws. The Netherlands also adopted new legislation during 1979 in an attempt to more closely regulate, and to some extent restrict, the employment of foreign workers. Although a number of measures previously introduced by the French Government to reduce the foreign labour force were declared unconstitutional, the Government has continued to press in this direction, approving a new series of restrictive measures during 1979.

Summarizing the situation in the major receiving countries: Austria's population has declined slowly in recent years, as a result of a deficit of births and a reduction in the stock of foreign workers. There have been no legal changes in Austria's international migration policy since 1976. Entry policy continues to be based largely on labour market considerations, with foreign workers being recruited on an annual basis for specified employment. The number of work permits issued in 1978 was, however, the lowest in a decade.

Although Belgium's volume of immigration has declined in recent years, there continues to be a slight excess of entries over departures. The Government has not limited immigration for the purpose of family reunion, nor has it attempted to induce workers, including those who are unemployed, to return to their countries of origin. In recent years, however, the Government has applied more rigorous legal measures to reduce clandestine immigration.

Belgium is one of several Western European countries that adopted new legislation to improve the situation of its foreign workers. In March 1979 the Government of Portugal ratified an agreement previously concluded with Belgium that includes a number of entirely new provisions: family reunion after one month, employment rights for members of the worker's family, the setting up of associations for Portuguese immigrants, and cooperation on vocational training activities that take into account an eventual return to Portugal.

The Federal Republic of Germany has adopted similar legislation. While it has kept an almost total ban on the entry of new foreign workers, other than those from EEC countries, the Government's policy permits the entry of family members and facilitates their subsequent access to the labour market. Whereas the spouse and unmarried children continue to be allowed to join a foreign worker after one year's residence of the latter, their eventual admission to work was modified in 1979, easing the situation of spouses and children of non-EEC foreign workers. Children will now be eligible to obtain a work permit two years after entry--or earlier if they have attended a vocational training course of at least six months duration. Spouses will, as a rule, have to wait four years before they can obtain a work permit in sectors of the economy suffering from a labour shortage. As an exception, in districts where shortages are particularly acute, a work permit may be issued after three years.

The integration of foreign children and young people is another major aim of the Government's policy and the object of extensive action by both the lander and the Federal Authorities. Plans have been formulated for the improvement of the transition from school to work and the reorganization of advisory and information services for migrants in general. Finally, within the framework of aid to return and development in the emigration countries, negotiations on training and investment assessment have been started with the Government of Greece and initial discussions held with the Government of Yugoslavia.

As a means of facilitating the integration of its foreign-born population, Switzerland recently modified its nationality laws. The country's overall policy remains governed by the Ordonnance of the Federal Council and states that the number of foreigners holding established or annual residence permits and engaged in gainful activity should be gradually lowered so as to maintain a reasonable balance between the Swiss and foreign population. The principal change in Switzerland's policy concerns the attribution of Swiss nationality. As of 1 January 1978, the child of a native-born Swiss woman and her foreign husband acquires Swiss nationality, provided only that the parents were domiciled in Switzerland at the time of the birth.

In the case of the Netherlands, legislation adopted during 1979 aims at regulating, and to a certain degree restricting, the use of foreign manpower. The Netherlands presently has a slight migration

surplus, as a result of a policy that permits reunion of the families of foreign workers. In the beginning of 1979, the country's New Act on the employment of foreign workers took effect. Under the Act, no employer may hire a foreign worker without a work permit issued by the Ministry of Social Affairs. (No work permit is required from foreigners with a residence permit, from citizens of EEC countries and from migrant workers who have been legitimately employed in the Netherlands for more than three years and possessing a permanent work permit). Applications for a work permit are to be submitted jointly by the employer and the worker, but the permit will be issued in the name of the employer--who is penalized in cases of infringement under the Economic Offences Act. To restrict to some extent the future entry of foreign workers, the Act introduces the concept of "permit quotas"--i.e., the maximum number of work permits that may be issued simultaneously in any enterprise.

In spite of the fact that a number of measures introduced by the French Government during 1977 1/--as a means of reducing the foreign labour force--were repealed as unconstitutional in 1978 by the Council of State, the Government approved a new series of immigration measures in 1979 (that were due to be discussed in the National Assembly in October). These measures are geared to reducing the foreign population in France by about 150,000 persons per annum, chiefly by means of not automatically renewing existing permits--something that the Government had done almost universally since 1974.

Under the proposed measures, the number of permits will be reduced to two types. An immigrant who has lived in France continuosly for 20 years may qualify as a "privileged resident" and will be issued a 10-year permit, as well as given a guarantee of automatic renewal. The second type of permit, the 3-year permit, is reserved for refugees. Although the Government envisaged that large numbers of foreign workers would return to their countries of origin during 1980, this did not in fact occur. Due, for example, to a protest from the Government of Algeria, France agreed to prolong all Algerian permits for a one-year period.

According to the provisions of another bill on the subject of illegal immigration that was presented by the Interior Ministry in 1979, the deportation of illegal immigrants will now be made easier, since their expulsion can be decreed by Interior Ministry officials, circumventing the courts.

1/ These measures included imposing a 3-year ban on immigration, terminating the issuance of work permits, extending return assistance to all workers who had resided in France for a 5-year period, suspending family immigration, and offering a cash bonus to those foreign workers who agreed to return to their countries of origin.

All countries in the region have continued to be actively involved in refugee resettlement. Summarizing recent developments in the major refugee-receiving countries:

- Austria, a country with a tradition of granting asylum to refugees from Eastern Europe, has continued to serve as a staging facility for Soviet emigrés.

- To date, Belgium has accepted more than 1,500 Indochinese refugees.

- Although the Netherlands has absorbed thousands of Surinamese in recent years, it agreed to accept some 1,000 Indochinese refugees during 1979.

- In spite of its small size and density, Switzerland has accepted large numbers of Indochinese refugees. As in the case of Sweden, its policy has been to accept hard-to-place refugees, such as those who are physically or mentally handicapped.

- France has a large refugee resettlement programme that admits 14,000 to 16,000 refugees per annum, although there have been reports that these numbers may be reduced. Because of ties stemming from France's former role as a colonial power in Indochina, the majority of the 1,000 to 1,200 refugees per month are from Viet Nam, Laos or Kampuchea. Refugee flows into France are of demographic significance, since refugees now constitute some 27 per cent of all immigrants.

- The Federal Republic of Germany continues to give top resettlement priority to ethnic Germans from the Soviet Union and Eastern Europe, of whom it accepted some 58,000 in 1978, although it has recently accepted smaller groups of non-German refugees, including some 3,000 Indochinese during 1978. At the 1979 Geneva conference, it raised its offer of resettlement places to 20,000, although there have been reports that it may decide to reduce its pledge.

Cyprus, Israel, Turkey (Non-Arab countries)

The 3 non-Arab countries in Western South Asia have had very different international migration trends. Cyprus, as a result of its rapid economic recovery, has had a continuing decline in emigration, accompanied by the gradual repatriation of many of its nationals who were uprooted in 1974. Unemployment, which was estimated at 35 per cent of the labour force in 1974, is now down to 1.8 per cent, and the country is experiencing labour shortages.

Although Israel remains one of the few countries at world level that desires increased immigration, the trend has run counter to the

Government's policies. According to a report of the Knesset Immigration Committee, 2,000 Israelis are emigrating each month, mostly to the United States of America. Some 25,000 Israelis are expected to emigrate in 1980, 10,000 more than the number who emigrated in 1979. If the present trend continues, more Jews will be emigrating from Israel than arriving from other countries, a phenomenon that is of serious concern to most Israelis. In addition to a rise in the emigration of Israeli nationals, there has been a decline in the number of Jews immigrating to Israel under the provisions of the Law of Return, by which any person of the Jewish faith may freely immigrate to Israel. Although Israel has received significant numbers of Soviet Jews in recent years, the percentage of this group choosing to settle in other countries is now more than 65 per cent.

Although Turkey has received a steady flow of return migrants since around 1974, some 759,000 Turkish workers, of which about 80 per cent were male, were living outside the country at the end of 1978, approximately 44,000 more than were living abroad in the previous year. Although the proportion of Turks residing in Germany is still about 70 per cent, there are now as many as 40,000 in Saudi Arabia and 22,000 in the Libyan Arab Jamahiriya, as well as smaller numbers in other non-traditional receiving countries. As a result of high unemployment and underemployment and generally unfavourable economic conditions, pressure to emigrate is expected to persist.

On the issue of refugee resettlement, although the situation has improved considerably, there are still some 8,000 Cypriotes in refugee camps. In addition to allowing the unrestricted immigration of refugees of the Jewish faith, Israel also accepts small numbers of non-Jewish refugees. At the 1979 Geneva conference, for example, it pledged to admit some 200 Indochinese refugees. The Government of Turkey continues to operate a refugee programme for ethnic Turks from such countries as Bulgaria.

Northern America

The major innovation of Canada's 1978 Immigration Act is that the Government now determines annual immigration quotas. As the Government reported in the Fourth Inquiry, "the flow may be increased, maintained or decreased each year, depending on economic conditions". The Immigration Act is notable in that it gives landed immigrants the same basic rights as Canadian citizens, with the exception of the right to vote. Moreover, an immigrant is allowed to apply to bring in his relatives as soon as he arrives in Canada.

Canada's cumulative intake of refugees has made it one of the largest contributors to Indochinese resettlement. Its unique system, which involves the Government's sponsoring one refugee for each one privately-sponsored, and which enables a group of 5 persons to sponsor a

refugee family, has surpassed expectations, providing 25,000 offers of sponsorship by December 1979, against the target figure of 21,000 which had been set for the period ending 31 December 1980.

Family reunification, rather than labour force needs, has been the cornerstone of the United States of America's immigration policy. Of the 7 preferences which define, limit and rank those eligible for the 290,000 numerically limited visas available, 4 preferences--comprising 74 per cent of the total visas--are reserved for close relatives of United States citizens and permanent residents. The major argument for maintaining heavy family reunion emphasis has been humanitarian concerns and the fact that familial ties provide a good foundation for the integration of new immigrants into society.

Because of the numerical ceiling (290,000), as well as per country limits (20,000) and preference limitations that strongly favour family reunification, over 790,000 persons were on lists at various visa-issuing ports throughout the world in 1978, waiting to immigrate to the United States. As a result, vast numbers of aliens are frustated by the United States immigration laws and attempt to violate these laws each year. The major portion of aliens attempt to circumvent the inspection process altogether by crossing the land border between posts of entry.

Concerned that illegal migration could no longer be controlled by existing law and practice, as it had in the past, the United States Government began in 1971 to explore policy alternatives for regulating the flow of illegal migrants. Since attempts by the Federal Government to formulate a policy on the illegal migration phenomenon have so far failed, state governments have increasingly attempted to control the situation within their own borders. The latest initiative by the Congress was the creation of a Select Commission on Immigration and Refugee Policy, which is mandated to study and evaluate existing laws and procedures governing the admission of immigrants and refugees, and to make recommendations to the President and Congress not later than 30 September 1980.

Although the overall evaluation of United States immigration policy is still in progress, the Government passed a new Refugee Assistance Act in February 1980 to establish a "permanent and systematic procedure" for admission and settlement of refugees in the United States". The Act broadens the definition of refugee status (which was previously limited to persons fleeing Communist or Middle Eastern countries) to incorporate the United Nations definition, and to include persons who fear persecution within their own country, and it establishes 2 basic categories: refugees and those seeking asylum. Whereas preceding legislation limited non-emergency admissions to about 17,400 per year, the 1980 Act expected to allow approximately 50,000 non-emergency refugee admissions for the years 1980-1982.

Subsequently, however, when the United States Government decided to treat the more than 100,000 Cubans, as well as large numbers of Haitians, who arrived in the country during the spring of 1980 as applicants for for asylum, the Government in effect created a separate category with no numerical limit.

Union of Soviet Socialist Republics

As a participant in various COMECON joint projects, the Soviet Union has employed mainly Bulgarians--in more than 20 large industrial projects--as well as thousands of Polish workers and technicians, and smaller numbers of specialists from various COMECON countries. It has, in turn, sent between 500 to 1,000 workers and specialists annually to most of the Eastern European countries.

The Soviet Government strictly controls entrance into and exit from the USSR, making family reunion the only justification for emigration, and retaining the prerogative of identifying appropriate family members.

Currently, the Soviet Government permits only 3 ethnic groups to emigrate in any large numbers: Jews, Germans and Armenians, each of which has a homeland outside of the Soviet Union. The emigration of Soviet Jews reached a record level of 50,461 in 1979. Soviet Jews continued to emigrate in the first few months of 1980 at about the same rate as in late 1979, although the flow subsequently began to taper off. As a matter of Soviet procedure, emigration visas usually list Israel as the country of destination , although the proportion of those actually going to Israel has been declining--to 40-50 per cent or less--with more Soviet emigrants preferring to go to the United States of America.

ECLA

Caribbean

Although the major migration flows in the Caribbean region have been outward, there has been some intra-regional movement of seasonal and temporary workers, accompanied by sizeable illegal flows to countries in the region such as Bahamas and Barbados that have higher per capita incomes.

The latter situation now appears to be changing. Although large numbers of Haitians have entered the Bahamas illegally since the early 1960s, many as a first step in stage migration to the United States, the Bahamas launched an intensive campaign in 1978 to rid the islands of illegal

migrants. Initially, it expelled some 20,000 illegal Haitians and then began an intensive campaign to expel an additional 30,000 to 40,000, setting a voluntary deadline of mid-1979, after which arrest and deportation were to be carried out. The Government of Barbados and Trinidad and Tobago have become similarly strict.

With the closing of many former avenues for permanent emigration from the Caribbean, there have been some attempts at setting up temporary labour schemes, although these have been generally unsuccessful. Jamaica, for example, entered into an agreement with Venezuela in 1979 for the export of temporary workers, but the experiment ended in failure when both countries argued that the other had violated terms of the agreement.

In addition to the continuing exodus of skilled personnel--over which most Caribbean governments have shown growing concern, but against which they have experienced little success--there is the largely illegal movement of unskilled workers toward such destinations as the United States of America, Puerto Rico and Venezuela. A number of governments have openly sanctioned this flow. The Dominican Republic, for example, has acknowledged the impact of emigration in bringing about a desired reduction in population growth, as well as the positive effects of remittances on its balance of payments. Likewise, in a number of official statements, the Government of Haiti has reported that remittances are an important source of revenue, and it has made no attempt to curtail the continuing flow of "boat people" to the United States.

The latter position raises an interesting point--namely, the problem of determining which persons are bona fide refugees and which are economic migrants. In the case of Haiti, while there has been a continuing movement of highly skilled Haitians to the United States, the latter country has been reluctant to accept the unskilled, particularly if they entered the country illegally, and its overall position has been that the Haitian "boat people" are economic rather than political refugees and should not be entitled to political asylum. However, in the wake of the United States' acceptance of large numbers of Cubans in the spring of 1980, its treatment of the Haitians was severely criticized, and it decided to accept both groups as applicants for political asylum. As of the summer of 1980 an average of 500 Haitians were arriving daily in the United States.

As noted, Cuba sanctioned the departure of over 100,000 persons--or approximately one per cent of its population--during the spring of 1980. The flow of refugees is unlikely to resume in the near future, since the Cuban Government formally rejected a request for negotiations from the United States, the United Kingdom and Costa Rica.

Middle America

There have been a number of policy changes in the sub-region, chiefly as a result of the displacement of hundreds of thousands of Nicaraguan refugees during 1978-1979. Costa Rica, a country that desires a continuing reduction in its population growth, has changed its position on immigration and now considers it to be too high, largely as a result of the influx of Nicaraguan refugees. At the Geneva conference in July 1979, Costa Rica withdrew its offer to accept several hundred Indochinese refugees, reporting that its refugee population, made up largely of Nicaraguans, constituted some 2 and a half per cent of its total population. The Government noted that it would be unable to accept additional refugees until a substantial number of Nicaraguans were repatriated. In the spring of 1980, however, Costa Rica agreed to serve as a staging area for the first flows of Cuban refugees and offered to accept some 300 Cubans for permanent resettlement. Honduras is the second country in the sub-region that has changed its position on immigration and now regards it as too high, largely as a result of the arrival of an estimated 100,000 refugees from Nicaragua. The Government's international migration policy, which has been in effect since 1971, has sought to maintain a balance at the regional level between the native and immigrant populations, to establish strong national population clusters along the frontiers, and to attract skilled immigrants. However, in spite of the Government's desire for selective immigration, the major flows have been largely unplanned and have consisted of illegal migrants from neighbouring countries in Middle America, followed by the more recent influx of Nicaraguan refugees.

Mexico continues to be a major emigration country, and illegal emigration remains a sensitive political issue for the Mexican Government. The present administration has acknowledged that the emigration of large numbers of undocumented workers to the United States is an important matter to be negotiated with that country. It has emphasized that the problem of emigration is closely related to that of unemployment and that Mexico does not currently have the capacity to fully resolve its unemployment problems, although increased assistance from the United States (through trade measures, for example) has been acknowledged to be a possible means of reducing the pressure on Mexican nationals to emigrate. Although hundreds of thousands of Mexican nationals leave the country legally as well as illegaly each year, few formal attempts have as yet been made to secure their return. In recent years, the Government has been primarily concerned with the human rights aspects of emigration and has urged the adoption of bilateral accords to protect undocumented workers. Mexico has been relatively unaffected by refugee movements. It has no formal refugee programme and handles requests for asylum on a case by case basis. At the 1979 Geneva conference the Government reported that it was not in a position to offer places for resettlement, due to its

high rate of population growth and the emigration of its own nationals as a result of unemployment pressures.

In contrast to Mexico's emigration, which has consisted largely of clandestine flows, El Salvador is one of the few countries at world level that has an explicit policy to promote the emigration of its nationals. Its Programme for the Settlement of Salvadorian Nationals in Bolivia involves the proposed transfer of unemployed urban workers and their families to agricultural colonization areas in Bolivia. Another programme involves the hiring of Salvadorian workers on fixed-term contracts for urban construction works in Saudi Arabia. (The Government signed an agreement with a private consortium to send some 5,000 semi-skilled Salvadorian Construction workers, although as of late 1978 only 35 workers had actually been sent). Although its emigration policy is largely in the planning stages, the Government has organized an ad-hoc commission at a high administrative level to develop an expanded emigration programme.

Temperate South America

Although Argentina continues to be one of the major destinations for Latin American migrants, the Government desires increased immigration, since it recognizes that, in spite of a policy of pro-fertility incentives, Argentina will not be able to achieve a rate of natural increase comparable to that of other Latin American countries. While the present administration has somewhat scaled down its expectations from the 5 million immigrants which were desired at the time of the World Population Conference, it retains its goal of attracting immigrants from Western European countries, although it has received only an insignificant flow of Europeans in recent years. The major immigration which it continues to receive is the largely illegal flow of some 40,000 persons per annum from Chile, Bolivia, Paraguay and, to a lesser extent, Uruguay and Brazil. The Government has been generally tolerant of this movement and granted an amnesty to some 150,000 illegal migrants during the 1970s.

While Uruguay desires an increased rate of population growth, the Government does not consider that immigration will be an important component of demographic change. The country lost about 10 per cent of its population through emigration between the censuses of 1963 and 1975 and economic difficulties have resulted in continuing out-migration to Argentina, a flow that will not easily be reversed.

Although Chile adopted a new national population policy in November 1978 and now desires to increase population growth, it will do so by modifying fertility and mortality, rather than by increasing immigration. The Government is reported to have refused offers by the Japanese and former Rhodesian governments to engage in planned immigration

schemes, largely as a result of political opposition from local groups. Furthermore, for a number of years Chile has had a net outward migration of both skilled and unskilled workers, including large numbers of political refugees.

There have been a number of policy changes in the sub-region affecting refugees, notably in Argentina. Whereas the thousands of political refugees from Chile, Uruguay and Paraguay who arrived in Argentina during the early 1970s were prohibited from seeking work, those who have arrived since 1976 have been regarded as immigrants. Moreover, in 1979 Argentina agreed to admit some 1,000 Indochinese refugee families, although it requested financial assistance for their resettlement. In recent years Argentina has, in turn, generated thousands of refugees, who have sought asylum throughout Latin America, as well as in Western Europe and the United States. At the 1979 Geneva conference Chile noted that, although it has had a tradition of granting asylum to refugees, it could not offer resettlement places to refugees from Southeast Asia, chiefly for economic and geographical reasons. Similarly, Uruguay has not participated in international refugee relief efforts.

Tropical South America

The major immigration flows in the sub-region have responded more to market forces than to governmental policies and have been directed both to countries with higher levels of development and to areas of high economic growth within countries with low overall levels of development. Venezuela remains the major pole of attraction in the sub-region. Although the Government desires to decrease immigration, the country has received the largest flows of any country in the region. While Venezuela has long been the preferred destination for Colombian migrants, its labour market has expanded greatly in recent years to attract migrants of all skill levels--from Colombia, Argentina, Uruguay, Peru and the Dominican Republic. In spite of official concern over the continuing influx, the creation of an agency for the recruitment of foreign workers, the signing of a labour import agreement with the governments of Spain and Portugal, and Venezuela's membership in the Andean Pact assures that selective immigration will continue. The largely illegal nature of the flow has made it difficult to control, however, and there has been a growing movement within Venezuela to safeguard the national identity. In addition, the alleged maltreatment of illegal workers has aggravated tensions between Venezuela and the major sending countries.

The immigration of large number of Brazilians into Paraguay, in the same decade that hundreds of thousands of Paraguayans were living abroad, is an illustration of the complex forces that have determined international migration in the region. Paraguay has long been a net exporter of migrants, particularly to neighbouring Argentina. Although it

has a high rate of natural increase, the Government considers its rate of population growth to be too low, since around 15 per cent of its total population were living outside the country as of the early 1970s. In the last several years, the direction of the flow has been reversed, and many Paraguayans are returning to their country of origin, due to the fact that construction of the Itaipú and Yactera dams on the Paraguayan/Argentinan border, and economic activity generated by groups of foreign colonists, has increased the attraction of Paraguay as a migration destination.

Two countries in the sub-region, Brazil and Peru, have recently adopted stricter policies with respect to immigration, although neither is a major receiving country. Brazil's weak immigration from neighbouring countries, in spite of the fact that it is one of the most economically developed countries in the sub-region, may be explained by its under-developed transportation infrastructure and by rather poor communications with other countries in the region. It is the composition, rather than the size, of recent flows that appears to have led to a change in the Government's policy. Stemming from concern over left-wing political acitvities involving foreign nationals, the illegal entry of refugees from Indochina, and the activities of foreign missionaries, the Government has drafted a new immigration law that, unless drastically amended, will subject foreigners to various new controls. A proposed national immigration council would monitor foreigners activities, regulate the treatment of foreign technicians temporarily in the country, and rigidly circumscribe the activities in which foreigners may engage.

Although Peru has received comparatively little immigration, in February 1979 the Government issued a new decree on the hiring of alien workers. Under the decree, nationals must account for the total staff employed in an enterprise during its first three years of operation and for 90 per cent thereafter. Employers hiring foreign workers must prepare and implement systematic plans for training nationals to replace foreign experts. The new decree also establishes a Permanent Board for Migrant Workers within the Ministry of Labour, which will review all applications for a labour contract with an alien, as well as applications for exceptions to the aliens' quota.

A trend observable in several countries in the sub-region is that of encouraging selective immigration. Since the publications of preliminary results of its 1976 census, Bolivia has attempted to attract immigrants as a means of achieving a larger population size. It established a National Immigration Council in 1976 and formulated an "open door policy", under which several categories of immigrants (spontaneous, directed and selective) were granted benefits ranging from free grants of land to duty-free imports of machinery and tools to promote their settlement in Bolivia. The Government's policy is, however, essentially selective, since it would like to attract skilled migrants and those qualified in land settlement. In the late 1970s it expressed a desire for some 150,000 immigrants of

European stock from countries in Southern Africa. This scheme did not materialize, however, and the only accord that it has signed to date was with the Government of El Salvador in 1978. Ecuador's international migration policy also favours selective immigration, as well as the repatriation of qualified Ecuadorian nationals. The Government recruits qualified migrants through its overseas consular offices and recently concluded an agreement with the Intergovernmental Committee on European Migration (ICEM) to recruit technicians and other qualified personnel.

Before concluding this brief discussion, it is important to cite the example of Colombia, a country with a rather unique international migration policy. The Colombian Government has treated international migration as an extension of migration within the country and has been one of the first labour-sending countries to regard its international migration policies as part of a broader scheme of socio-economic development. The Government's labour migration policies aim to retain migrants in their place of origin, but to assist those who make the decision to migrate in finding satisfactory employment both within and outside Colombia. Toward this end, SENALDE continuously evaluates employment conditions in various regions of the country and channels workers to regions where there is labour demand. In addition, five Border Offices for Employment and Labour Migration have been established along Colombia's borders with Venezuela, Ecuador, Brazil and Peru, in order to assist return migrants in finding employment.

Most countries in the sub-region have participated to only a limited extent in international refugee relief efforts. Although Venezuela continues to accept some political refugees from other Latin American countries, the Government maintains that it is not in a position to receive refugees from outside the region. Bolivia has not participated to any extent in refugee relief efforts, while Colombia accepts only small numbers of refugees on a case by case basis. Ecuador has accepted a considerable number of political refugees from other Latin American countries, but has not recently been involved in refugee relief efforts, while Peru's recent economic difficulties have limited its ability to contribute.

Several countries in the sub-region have recently changed their position on refugees. In late 1978 Brazil withdrew from ICEM, citing its lack of need for immigrants and ICEM's shift in focus from European migrants to Southeast Asian refugees. At the 1979 Geneva conference it noted that its high rate of inflation and continuing unemployment, as well as the difficulties which it had encountered in assimilating previous Asian immigrants, were further reasons for its rejection of resettlement proposals involving Indochinese refugees. In addition, Brazil's new immigration law will affect hundred of thousands of refugees from other Latin American countries who reside at present in Brazil, since the law provides that

foreigners in a clandestine or irregular situation may not legalise their stay. The Brazilian Government maintains that these persons should apply for assistance from UNHCR, although few are likely to meet UNHCR's criteria. Finally, Paraguay, which has traditionally accepted large numbers of refugees, has now modified its position, as a result difficulties which it encountered in a recent experiment with resettling Korean immigrants and Indochinese refugees.

Guyana, a country with vast undeveloped tropical areas, is the only country in the sub-region that has been willing to accept large numbers of Indochinese refugees. In 1979 a consortium of private religious groups attempted to arrange for several thousand (and eventually 30,000) Laotian refugees to be relocated in a remote area of Guyana. As of December 1979 the Prime Minister of Guyana had responded positively to a proposed plan for the resettlement of some 750 Laotian refugees, although the refugees themselves subsequently declined the offer.

ECWA

Western South Asia (Arab countries)

The large flow of foreign workers into the oil exporting countries of the Middle East has continued in recent years, although possibly at a slower rate than during the early 1970s. The greatest inflow has occurred in the United Arab Emirates. As is the case in several other countries in the region, the Government recently decided to tighten its labour laws. Foreign workers--including some 400,000 Indians, Pakistanis and Bangladeshis--were given until June 1980 to regularize their papers and to comply with U.A.E. labour laws stipulating that foreign workers must be sponsored by a U.A.E. citizen or by a recognized company. All persons working for employers other than their original sponsors, or those who were sold sponsorship papers and then found work themselves, will face deportations, while those without passports may be jailed prior to their expulsion.

Saudi Arabia remains a major country of employment, although it too has tightened its regulations governing the employment of foreign workers. In contrast to the position of the other major countries of employment in the region, Arabs constituted 91 per cent of Saudi Arabia's total migrant labour force as of 1975. This difference arises partly from the Government's policy of giving priority to Arab applicants for work permit as well as its proximity to, and common borders with, the major suppli rs of Arab labour--i.e., Democratic Yemen, Jordan, Oman and Yemen.

The Government of Saudi Arabia has attempted to legalize and formalize all employment in the country, including that of the growing number of foreign workers. At present, every migrant worker in the country is required by law to have a sponsor. To facilitate this sponsorship provision, an amnesty was declared in early 1978, during which migrants without sponsors or work permits were allowed to register without penalty. In spite of these efforts, clandestine movements have continued. In 1979 the Government deported large numbers of illegal migrants and was reported to be considering setting up a computer system to carry out checks of possible illegal migrants, since uncontrolled immigration is perceived to be a threat to the Islamic basis of the Saudi regime.

Kuwait, the country with the largest population and greatest oil reserves among the Gulf States, has adopted a similar position. Although its development has been expedited by the employment of large numbers of Jordanians and Palestinians, as well as Iraquis, Lebanese and Syrians, the Government has become increasingly concerned over the high proportion of foreigners in the labour force. Reflecting this concern, a decree was issued in March 1979 by the Kuwait Social Affairs and Labour Ministry, regulating work permits for foreigners employed in the private sector. Under the terms of the decree, an employer wishing to recruit a foreign worker must apply to the Ministry for a work permit. Unless otherwise stipulated, the employer is responsible for repatriating the worker at the end of the contract or if the contract is terminated by mutual agreement.

Although it has one of the more diversified economies in the Arabian peninsula, Bahrain has not been able to afford foreign manpower on as large a scale as some of the other Arab countries. Although it had some 30,000 expatriate workers as of 1975, who made up 40 per cent of the labour force, it has been less dependant on foreign labour than the more capital-rich countries. Since it has been less able to compete for Arab labour, it has employed growing numbers of Asian workers, whose share in the total immigrant population rose from 32 to 64 per cent during 1971-1977.

In Qatar, a capital-rich state with a total population of only 67,900 as of 1975, foreign workers made up over four-fifths of the labour force both in 1970 and 1975. Whereas migrants in the public sector are virtually all Arabs, largely from Egypt, the private sector is dominated by non-Arabs, although the demand for their labour has fluctuated from year to year.

Examining the situation in the major sending countries, Jordan, like Egypt, has a tradition of supplying expatriate labour within the Arab world. Although there are fewer Jordanians abroad than Egyptians as a result of Jordan's smaller population size, they make a more significant

contribution to the Jordanian economy, which is based largely on remittances. There is an important and growing trend among Jordanian migrants, particularly the more highly qualified, towards taking up permanent residence in countries of employment, a trend that is largely a result of the Jordanian Government's liberal attitude toward emigration. The Government maintains its policy of placing no restraints on the outflow of labour or skills, even though the economy has begun to suffer acute labour shortages in recent years.

Oman continues to be both a sending and a receiving country for migrant workers. Rural Omanis migrate abroad for employment in Saudi Arabia or the United Arab Emirates, although their numbers, and thus their remittances, have fallen off in recent years. This outward movement of Omani nationals has had a serious disruptive effect on the rural economy. The growing employment of Asian labourers in the country's rural areas has not alleviated the problem, since the Asians are usually employed in the service sector, and not as agricultural workers.

Another important sending country is the Syrian Arab Republic, a country with a history of permanent emigration of families, followed by the more recent phenomenon of the temporary departure of males. Syrians have been drawn to Jordan in large numbers to serve as replacements in the labour force for Jordanians who have left, a movement which has been aided by the fact that Syrians do not need visas to work in Jordan. Since this movement has led to domestic labour shortages, the Syrian government at present has a policy of discouraging emigration. Although the departure of government employees has been effectively curtailed, skilled and semi-skilled manual workers, as well as the unskilled, continue to emigrate, since they have been less amenable to government control.

Yemen continues to be a major supplier of labour to Saudi Arabia and the other Gulf States. Although remittances have been of great importance to its economy in recent years, there is some dispute both in the theoretical literature and within Yemen itself on the economic costs vs. benefits of migration. The Government has generally held the view that migration is depleting the work force of its more able members, bringing about a decline in agricultural productivity, and causing domestic inflation by sudden large cash inflows to the economy. It has attempted to place some controls on the flow of migrant labour, although these have generally been ineffective.

Data on the labour force of Democratic Yemen are difficult to acquire. It is known that substantial numbers of its nationals have returned from Saudi Arabia in recent years, although the rate of return has possibly been declining.

ESCAP

China

In August 1979 China's international migration policy changed significantly, when it signed an accord with an Italian-based construction firm for the export of Chinese manpower. (Although Chinese workers were previously sent abroad for railroad construction work in Zambia and Tanzania, the Sino-Italian accord was the first to involve a developed market economy). At present, the Chinese Government offers teams of up to 500 workers for overseas construction projects. In early 1980 two Japanese firms agreed to hire teams of Chinese workers for highway and hospital construction projects in Iraq.

Another recent change in China's international migration policy has been the imposition of strict controls on illegal migration to Hong Kong. In 1979 the British Government exercised diplomatic pressure to induce China to curb the flow, and the Chinese Government complied, instituting strict penalties (such as 5 years' hard labour for a first offense and execution for a third attempt). Nevertheless, in spite of stepped-up border patrols and the construction of a high fence along both sides of the border, some illegal migrants leave China by boat, while there is a continuing influx of some 200 legal "visitors" per day who overstay their visas and eventually obtain Hong Kong identity cards.

China is one of the few centrally planned countries that have accepted large number of refugees. During the period from April to July 1978, after which it closed its borders, China accepted some 230,000 to 250,000 Indochinese refugees, whom it has regarded as returned overseas Chinese. These refugees, as well as other overseas Chinese who have voluntarily returned, have been settled on state farms or in industry in certain designated provinces such as Guanxi, Guangdong, Fujian and Yunnan.

Japan

Although Japan is neither a labour importer nor exporter of any significance, a number of Japanese firms have been offering teams of Chinese workers to third countries for use on overseas construction projects, such as a number of highway and hospital construction projects planned for Iraq.

Since it is an island nation with a homogeneous population that does not easily assimilate foreigners, Japan has been little affected by illegal population movements. Although it has provided first asylum to small numbers of "boat people", it has been critized by various refugee-

receiving countries for not accepting larger numbers of Indochinese refugees for permanent settlement. (Even the small number of refugees that Japan has admitted on a permanent basis must apply for new visas every year for at least 10 years and are unlikely ever to be eligible for Japanese citizenship). At the 1979 Geneva conference the Government defended its position on the grounds that, as a result of linguistic and other assimilation problems, a majority of refugees who had been admitted had left voluntarily for third countries. Although it pledged in the spring of 1979 to underwrite 50 per cent of the UNHCR's 1980 Indochina refugee budget, and to accept 500 Indochinese refugees, it has not been able to fill its quota, due to the strict criteria for admission which remain in force.

Other East Asia

Although the Republic of Korea has had a downturn in fertility, the Government desires a reduction in the rate of population growth, partly as a result of continuing unemployment. In recent years, it has developed a highly organized "project package" approach to labour migration, which involves supplying total projects from design through execution to Middle East markets. Although such projects provide manpower--including management and skilled through unskilled personnel--along with machinery and supplies, the Government is not interested in manpower export per se. In fact, it has moved to prohibit recruitment of Korean construction workers by foreign firms.

A peninsula nation which shares a tightly-controlled border with the Democratic People's Republic of Korea, the Republic of Korea is a racially homogeneous society with no minorities. It has offered asylum to those Indochinese refugees who have been rescued at sea and brought to its port. However, as the Government noted at the 1979 Geneva conference, a majority of these refugees subsequently chose third countries for resettlement, due to such factors as the language barrier and Korea's limited employment opportunities.

The Government of Mongolia, as a result of severe manpower shortages in almost all sectors of the economy, has permitted the temporary immigration of labourers from the USSR and other COMECON countries, under special contracts with respective governments. Apart from the temporary residence of Mongolian students in various COMECON countries, however, there is no sizeable emigration from the country.

Eastern South Asia

In Eastern South Asia the major intra-regional flow of labour migrants has been that of Malaysian workers to Singapore, a country to which they have been drawn by higher wages. The future of this flow is

now uncertain, however, due to incipient changes in Singapore's manpower recruitment policies. In recent years, as a result of Singapore's successful industrialization programme, the densely populated city-state has experienced labour shortages in the manufacturing sector. Manufacturing firms have taken on large numbers of Malaysians and somewhat smaller numbers of Thai workers, although the recruitment of foreign labour has been considered to be a temporary measure, since Government planners have felt that encouraging more technologically advanced industries and increasing the participation of women is a better long-term solution. Recently, a number of manufacturing firms in Singapore have raised their starting salaries by 10 to 20 per cent as a means of attracting native workers, following the Government's imposition of stricter controls on the employment of foreign unskilled labour and its rejection of a number of applications to import workers from Thailand, Sri Lanka and Indonesia. The Government of Singapore is also reported to be considering somewhat of a revision of its anti-natalist policies.

A majority of the labour-exporting countries in the sub-region now send workers outside the region, principally to Middle East markets. In recent years, the Philippines has developed a highly organized system of labour recruitment that is similar to the Korean model, although it differs to the extent that the Philippines supplies workers for foreign companies, as well as professionals and a large group of merchant seamen. The Philippines Overseas Development Board, one of several institutions that was chartered to deal with the country's "temporary excess of manpower", has recruited growing numbers of Filipino workers. (A labour pact signed by the Philippines and Libya, for example, in the fourth quarter of 1979 represented nearly a 40 per cent increase over the numbers recruited in the previous year). In addition to this organized flow, illegal Filipino migrants--primarily domestic workers--have been reported in Italy and in several other European countries.

Thailand is another country in the sub-region in which the recruitment of labour migrants has increased significantly in recent years. Whereas the Labour Department recorded fewer than 1,000 Thais working abroad in 1975, their numbers are now estimated at as many as 50,000. Once confined largely to the contruction field but now moving into various service industries, Thai workers are currently employed in Bahrain, Kuwait, Qatar, Dubai, the United Arab Emirates, Iraq and Libya, as well as in nearby Singapore. Finally, Indonesia also sends manpower to Middle East markets, although its manpower export has been of a smaller magnitude and generally less organized than in some neighbouring Asian countries.

Of course, the major international migration flows in the region in the past 2 years have been those involving refugees. One major refugee upheaval in the sub-region has now virtually been resolved.

During 1978 an estimated 200,000 Burmese Muslims fled across the border to neighbouring Bangladesh, a movement that was precipitated by a census in the Arakan border region of the Muslim minority, who are citizens of Burma, but who have sometimes been apprehended as illegal migrants. In July 1978, Burma and Bangladesh reached an agreement to return those refugees who could produce evidence of their prior legal residence in Burma, and to cooperate to prevent future illegal border-crossing between the countries. The outlook as of late 1979 was for the eventual repatriation of a large proportion, but not all, of the refugees. Those refugees that could not or would not return to Burma were primarily ethnic Bengalies whose ultimate status was to be decided upon by the Government of Bangladesh.

The situation involving massive flows of Indochinese refugees to various countries within Southeast Asia remains far from being resolved. Briefly summarizing the position of the major receiving countries:

- Prior to 1979 Indonesia received few Indochinese refugees. When the Government of Malaysia hardened its policy, however, during 1979 and refused to admit the growing influx, many of the refugees who were rejected by Malaysia were believed to have made their way to Indonesia, whose refugee population grew by about the number that Malysia pushed back out the sea.

- The Philippines has both generated and received refugees. Some 90,000 Filipino Moslems now reside on the Malysian island of Sabah, where they make up a major part of its population. The Philippines has provided fist asylum to some 11,000 boat refugees. Although this is a smaller flow than received by other countries in the region, the Philippines joined with Indonesia, Malaysia, Singapore and Thailand in June 1979 in announcing that it would not accept additional refugees. At the Geneva conference, however, in July 1979 the Philippines offered UNHCR an island to serve as a refugee processing centre.

- Although Singapore has cooperated in arrangements for the transit of refugees from Indonesia and Malysia en route to resettlement in other countries, it does not accept refugees for permanent resettlement because of its high population density.

- Malysia, which once considered immigration to be satisfactory, now considers it to be too high, based upon its refugee influx. The country has given temporary asylum to some 118,000 Vietnamese refugees since 1975, making Malaysia a major country of first asylum. Although it initially considered the boat refugees to be illegal immigrants and confined them to camps, Malaysia's refugee policy was essentially humane. The heavy exodus in 1979 put this policy under strain, however, and Malaysia came to the forefront of world attention as a result of its decision to refuse to accept additional refugees and to force refugee

boats into international waters, a policy that it adopted to reduce the flow of refugees at the source and to heighten pressure on Western countries to relive Malaysia of its refugee burden. Although there was a net decrease in the number of refugees in Malaysian camps during the third quarter of 1979, the Government indicated that it would remain firm if a new influx were to occur, since it feared that the refugees, who are largely Sino-Vietnamese, would remain in Malaysia, upsetting the balance between the predominant Malay community and the Indians and Chinese who make up half of the population.

- Finally, Thailand has borne a heavy burden, as the principle country of asylum for land refugees from Laos, Kampuchea and Viet Nam. In view of fear of invasion across the Kampuchean border and differences with Laos along the Mekong River, refugees were originally treated as illegal immigrants upon their arrival in Thailand. Border authorities frequently tried to dissuade refugees from entering the country and, on several occasions, they were forcibly repatriated on the grounds that they were economic refugees or illegal entrants. This was the case in June 1979 when the Thai Government forcibly expelled more than 50,000 refugees from Kampuchea. Subsequently, at the urging of Western nations, Thailand decided to open its borders to a huge flow of refugees from the some 560,000 Kampucheans camped along the frontier.

Thailand will not consider permanent resettlement of its refugees until their numbers have been substantially reduced. Like the Government of Malaysia, the Thai Government has been concerned by the net increase in the camp populations, for, unlike the boat refugees, whose stay in the camps has usually been a matter of months, large numbers of land refugees have remained in various Thai camps for as long as 4 years.

Conversely, summarizing the situation in the major sending countries:

- As of June 1980 there were some 800,000 refugees from Democratic Kampuchea in Thai camps and along the frontier areas, many of whom have been awaiting resettlement since 1975. Unlike their Vietnamese and Laotian counterparts, who were granted refugee status in Thailand, the Kampucheans were initially considered to be illegal aliens by the Thai authorities and were expelled from Thailand. Allowed to return and confined in camps, the Kampucheans have been generally ineligible for resettlement in a country such as the United States, since they do not meet certain criteria for the admission of Indochinese refugees (these criteria include having immediate family members in the United States, having had close association with the United States Government etc.).

In mid-June of 1980 a repatriation programme was begun by the Thai Government and United Nations refugee officials, in response to what they said were requests from many of the refugees to be allowed to return

to Kampuchea. Although nearly 7,000 refugees were repatriated before border hostilities brought a halt to the programme, a majority chose not to be repatriated.

- Approximately 150,000 refugees from Laos--including Lowland Lao as well as refugees from the Hmong hill tribes--are presently living in UNHCR-financed camps in Thailand. Many of the refugees, who continued to seek asylum in Thailand at a rate of about 6,000 per month during 1979, are Sino-Lao from urban areas who were identified with the merchant class, or who had associations with the former regime.

- Finally, in the case of Viet Nam, there was a sharp increase in the number of refugees leaving that country beginning in the spring of 1978, largely as a result of various policies (such as regulations abolishing private business) designed to impose the political, social and economic patterns of the North of the country on the South. The business and professional middle class, which included most of the Chinese community, as well as others considered surplus to the cities, were left with no other options than emigrating or settling in the remote New Economic Zones. The departure of large numbers of ethnic Chinese during 1978 and 1979 was followed by that of numbers of ethnic Vietnamese, many of whom bribed officials to obtain Chinese identity.

During 1979 regional and international resentment grew over what was seen as Viet Nam's expulsion of an unwanted population, with profits to the Government greater than any foreign exchange source. Following the 1979 Geneva conference, Viet Nam adopted a self-imposed moratorium on the exodus of refugees. Although the volume of departures declined considerably, it resumed significance in the following year.

A number of countries, including the United States and Canada, permit legal immigration of Vietnamese refugees, primarily on a family reunion basis. In May 1979 UNHCR signed an agreement with the Government of Viet Nam, following its announcement that it would permit legal emigration. As of 1979, details were being worked out as to the type of offices that would be set up in Viet Nam to select and process those permitted to depart.

Middle South Asia

While no country in the sub-region desires significant immigration, several encourage emigration. The Government of Pakistan, which has long desired to increase emigration, is taking a more active role in regulating the outflow of migrant workers, who now depart for many new destinations along the Persian Gulf. Under its Emigration Ordinance of 1979, the Government introduced measures for regulating the recruitment of Pakistanis who desire to leave the country to work abroad. The new regulations,

which provide for the establishment of a Bureau of Emigration and Overseas Employment, stipulate that all overseas recruiting agents must apply for a licence. Given the Government's longstanding concern with the emigration of qualified personnel, permission to recruit individuals for overseas posts will be denied if the Bureau considers such emigration to be a brain or skill drain. Unlawful emigration is now subject to 5 years' imprisonment and/or a fine (7 years for a second offence), while unlawful recruitment is liable to up to 14 years' imprisonment or a fine or both.

Along with the other labour supplying countries in the sub-region, Bangladesh has stepped up the export of manpower for overseas construction projects. Unlike those countries that sell whole project packages, Bangladesh provides manpower alone to Middle Eastern employers or third-country contractors in the Middle East. The Government apparently expects this flow to continue, for it has included minimum quinquennial targets for overseas workers to the Middle East in its 20-year plan for 1980-2000.

Sri Lanka is another country in the sub-region that is sending temporary workers to an increasing number of destinations. More than 50,000 Sri Lankans were working along the Persian Gulf during the late 1970s, with a majority in Saudi Arabia, Kuwait, the United Arab Emirates and Oman. Sri Lankans are also employed in the Federal Republic of Germany. Although the Government condones the emigration of unskilled labour, it is concerned by the departure of qualified personnel and requires a compulsory period of government service for certain professional categories. India has been developing project export to some degree. Although the Indian Airport Authority and other private and public concerns are becoming active in overseas project work, the Government does not emphasize project and manpower export to the same extent as some other Asian countries, partly because India is a continental economy and traditionally inward-looking.

Bhutan, the only country in the sub-region that desires to attain higher rates of population growth, has been little affected by international migration, with the exception of the estimated 4,000 Tibetan refugees who have remained in the country since they fled from their homeland in 1959. In 1979 the National Assembly of Bhutan decided that the Tibetans had either to accept Bhutanese citizenship or be repatriated to China at the end of 1980. Bhutan subsequently changed its position, however, and has given the refugees the option of resettling in India.

Bangladesh has been affected by refugee movements of considerable scale. Some 200,000 Burmese Muslims from the Arakanese border began crossing into Bangladesh in the spring of 1978. In that same year the two governments agreed to a repatriation scheme that has been generally successful, for there were fewer than 10,000 refugees remaining in

Bangladesh as of 1979. A refugee situation of longer standing is that of the Bihari refugees, non-Bengali speaking residents of Bangladesh who claim to be citizens of Pakistan. Many of these refugees have remained in camps since the 1960s, although their numbers have been somewhat reduced by assimilation.

India was seriously affected by communal violence during 1980, much of it involving Bengali immigrants. Some 243,000 refugees were driven into camps in Tripura State when discord between tribal people and the mostly Hindu Bengali immigrants from what is now Bangladesh erupted in a fierce conflict in June 1980. A similar campaign against Bengali immigrants has been conducted in Assam State. Some Indian nationals would like to ease tensions by deporting those immigrants who arrived after 1971, as opposed to those who arrived in the wake of partition.

The most serious refugee situation in the sub-region, and one of the most serious in the world, has involved the massive influx of refugees into Pakistan, a country that has long attempted to stimulate emigration to relieve its own population pressures. By mid-1980 Pakistan had received nearly one million refugees from neighbouring Afghanistan--about 7 per cent of that country's total population. Although the numbers remain uncertain, since many of the refugees are tribal people from ethnic groups that inhabit both sides of the porous Afghan-Pakistani border, it is certain that the refugee situation has put an enormous financial and administrative burden on Pakistan, which has been the major receiving country, followed by Iran, which has received at least 100,000. Although the earlier flows consisted largely of rural Afghans, there has been a new and growing exodus by Kabulis and other urbanized groups.

Australia-New Zealand

In 1978 the Government of Australia announced a new immigration policy which was expected to attract some 210,000 immigrants during the next three years. Noting the desirability of maintaining a steady rate of immigration, and to provide a reliable basis for planning in the public and private sectors, the Government reported that it would implement a triennial rolling immigration programme, commencing with the period 1978/1979 to 1980/1981, a system that would allow for flexibility on an annual basis.

The implementation of the new immigration policy has met some opposition in Government circles. The announcement of a higher immigrant intake of 87,000 in the third quarter of 1979, for example, led to charges that the policy would lead to worsening unemployment.

During the period from 1975 to 1979, Australia accepted some 21,500 Indochinese refugees, including more than 2,000 direct arrivals, and it expected to admit a total of some 32,000 by June 1980. This would result in a higher ratio of refugees to population (1:290) than in any other major country of resettlement.

New Zealand's policy of maintaining its moderate level of immigration, which has been in effect since early 1976, aims for an annual net immigration of only about 5,000 persons. In its reply to the Fourth United Nations Population Inquiry, the Government reported that "migration is currently limited to specific occupation groups whose skills are in demand and to humanitarian cases such as refugees and family reunification. This is a reflection of the current economic situation in New Zealand and the consequent level of unemployment of citizens and permanent residents".

Recently, more persons have been emigrating from New Zealand than have been arriving. In 1978, for example, there was a net loss of some 27,000 persons--in a country which registered a gain of 26,000 as late as 1973. The free transfer of emigrants' assets to their new countries of residence is creeting an additional burden on New Zealand's balance of payments; thus, the emigration problem has become a source of serious concern. Noting that the rise in departures since 1967 has been both exponential and steady, a Government publication reported that some minor changes had been made in New Zealand's immigration policy in 1979. The Government will now consider the application of persons who do not have a specific skill in demand, but who have sufficient capital and expertise in the entrepreneurial field to qualify for permanent residence.

New Zealand has been among the first 5 countries in refugees settled per capita. It has permanently resettled over 1,100 Indochinese and plans to admit about the same number during 1980. At the Geneva conference in July 1979 it agreed to accept another 1,800 refugees by June 1981, by which date one in every 1,000 New Zealanders will be an Indochinese refugee.

Conclusion

The following brief conclusion will highlight some of the major problems with respect to international migration, with highlights from several of the major world regions.

With regard to Western Europe where migration has basically stopped, the migrant problem is now one of stocks rather than of flows. Although the size of the foreign population in and outside the labour force is continuing to increase in most host countries, this has been a result of families being reunited and the birth of children. There seems little possibility of a return to the mass migration of the 1960s, since most Governments appear to have made a firm decision that future economic growth will depend on more advanced technology rather than an abundance of labour. (This strategy is apparent in France, for example, where the Seventh National Plan, in contrast to preceding plans, calls for the substitution of capital for labour and the reintegration of indigenous workers into jobs once held by migrants).

In Western Europe, the former host countries are now undergoing profound transformations, largely as a result of their past laissez-faire policies toward the movement of millions of persons. Western European guest worker policies were designed to control the inflow of foreigners, rather than their stock or return flow, and the numbers present or returning were expected to be regulated by the interplay of market forces and the return orientation attributed to migrants. Of course, one of the major problems has been the de facto permanence of millions of "temporary" guest workers. The presence of highly visible immigrants groups, inferior socially and economically to the national populations, poses serious problems for policy-makers in many of the Western European countries. Moreover, the presence of a whole generation of youth growing up with hyphenated identities in countries that do not even have these concepts as part of their cultural framework is a further example of the changes taking place.

At present, the policies governing the lives of foreign workers in most Western European countries are a patchwork of confusion and contradiction. Some Governments admit them to citizenship in due course and allow them some of the rights attached to citizenship in the interim. Others treat them as temporary workers, ineligible for many social welfare benefits and economic and political rights. Although there has been some progress in the past 2 years--the Federal Republic of Germany, for example, passed recent legislation that will allow the spouses of foreign workers to seek employment; Belgium and Portugal ratified an agreement that will allow family reunion within a period of months, while Switzerland changed its nationality law--there is a great gap in a majority of countries between pronouncements of concern for the integration of workers and actual policies.

In spite of the problems now affecting many of the Western European countries, receiving countries have derived many benefits from migrant labour, which has contributed to their domestic product and made their manufacturing industries more competitive. Moreover, at world level, countries that import labour have been in a better position to control migration flows to suit their needs than have countries that export labour, which have been buffeted by fluctuations in the demand for labour and in remittances.

On the subject of remittances, many of the labour-exporting countries have shown resourcefulness in designing policies to attract remittances from their expatriate workers, but they have given much less attention to the utilization of these remittances, a crucial factor in determing their impact upon a country's development. The IMF Compensatory Financing Facility has recently been extended to cover fluctuations in remittances as well as ordinary export earnings, which is an important step in the right direction, although there is a need for more bilateral cooperation for meeting the adjustment problem.

With respect to the reinsertion of returning workers in their countries of origin, it is obvious that economic development cannot take place as a result of the return of a disorganized mass of unskilled labour. A number of labour importing countries in Western Europe assisted in setting up training programmes for returning migrants, although these have not generally been successful. Even if returning migrants are trained, most of the labour exporting countries are unable to absorb more than small numbers of skilled technicians and managers, since the basic problem remains the lack of employment-creating investments. It is clearly necessary for countries to implement an integrated policy package covering the entire "migratory chain", that is, the process of migration, its overall socio-economic effects, and the optimal allocation of remittances in employment-generating projects.

Examining the situation in another major world region, the capital-rich countries of the Middle East have been growing in importance as labour importing countries, and are beginning to recruit workers from many of the countries that formerly supplied Western European markets, as well as from a growing number of Asian countries. The swing to Asian labour is the result of the concurrence of a variety of social and economic policy aims of the governments of the capital-rich states. Concern is growing in many of these countries over the wider social implications of hosting large migrant populations. Apart from fears of numerical domination, there is concern over the cultural impact which the large expatriate communities may have on the host societies. A policy that has increasingly been adopted has been to develop "enclave" industrial areas, where workers are channelled to new industrial areas that are apart from urban areas, thus minimizing the cultural impact of the foreign workers. Unlike the situation in

Western Europe, where market forces were the major determinants of return migration, a majority of workers in the capital-rich states are employed on fixed-term contracts and return to other countries of origin upon expiration of these contracts.

While governments of the labour-sending countries have become increasing involved on the recruitment end, either by regulating or sometimes providing recruitment services, they have been less involved with other aspects of the migratory chain. Little emphasis has been given to the problem of the reintegration of returning workers, although this may be related to the fact that the migrant streams are not very mature. There is little hard data on the uses made of remittances from workers in the Middle East, although there is impressionistic evidence that it has led to an increase in land prices and to wasteful consumerism. Moreover, although it is well known that the absence of male workers can have important effects on community structures and family life, there are almost no countries, with the exception of Korea, that have any sort of policies for the maintenance of family and cultural ties.

A serious problem is that of dealing with possible fluctuations in future labour demand. Although the more "package export"-oriented countries have given more attention to the current and future impact of manpower recruitment on domestic needs, those countries that emphasize manpower export have chiefly focused on immediate recruitment needs, with less attention to future demands. While some of the "package export" countries are exploring avenues for future immigration, on the assumption that Middle East markets will not gow indefinitely, others seem to count on over-expanding markets. (Bangladesh, for example, has included ambitious targets up to the year 2000 for manpower export to the Middle East).

A caveat is in order at this point. There are major differences in the demographic context of manpower migration to Western Europe and to the Middle East. During the 1960s the Western European countries required immigration to compensate for a shortage of low skilled labour, resulting from such factors as declining fertility and rising levels of education. Even at present, immigration for the purpose of family reunification is generally tolerated in the aging societies of Western Europe, since bringing in immigrants helps to maintain a certain demographic dynamism. In contrast, many of the labour importing countries in the Middle East have rapid population growth although a small population size. Some of these countries, which are presently in the labour-intensive construction phase of their development, will only temporarily need manpower until they are able to meet their own manpower needs. Clearly, there will be much uncertainty in the future.

A frequent slogan in the debate on international migration in recent years has been that "it is clear that capital should go to meet the men rather than the contrary". With few exceptions, however, this growing awareness among policy-makers of the comparative advantages of relocating industry rather than people has not yet resulted in practical action. In general, there is a pressing need for bilateral and multilateral agreements to regulate international migration--as recommended by the WPPA--in order to even out fluctuations, make remittances more predictable, and assist return migration when it occurs. Steps in this direction have been taken within the OECD in Europe, but similar measures are needed elsewhere.

The discussion to date has focused on organized migration flows. It is well known that a considerable and probably growing proportion of labour migration is of an illegal nature. Indeed, in some regions of the world, particularly in Africa and Latin America, illegal migration is the dominant type. Even in some economically advanced countries illegal migration serves the purpose of a de facto guestworker system. Receiving Governments can choose to ignore the presence of illegal workers in times of economic expansion and then suddenly tighten up during an economic downturn. Although the major burden falls on the workers themselves, who suffer violations of their civil and human rights, the receiving countries are faced with growing problems. Even those countries with accurate data-gathering systems have little idea of the actual number of illegals, to what extent they use basic services, whether or not they displace native workers, depress wages etc.

Even in the absence of hard data on illegal flows, there is a tendency for a large number of governments to be moving in the direction of stricter controls over illegal migration. For the most part, these actions are being taken unilaterally by receiving countries. There have been some attempts by groups of receiving countries to work in concert, but less evidence of effective formal cooperation on this issue between sending and receiving countries.

A final word must be said on the problem of refugees. It is important to note that a number of the countries that have changed their perception of international migration during the period 1978-1980, have done so largely as a result of an influx of refugees. In those countries that accept immigrants for permanent settlement according to a quota system, refugees are in a sense competing with more traditional migrants for a limited number of places (and vice versa). In spite of their humanitarian sentiments, a number of Western countries have often treated refugees as immigrants, admitting groups on a highly selective basis. (The United States of America for example, does not accept refugees from what was formerly Viet Nam, while refugees from Kampuchea account for only 5 per cent of the total number of Indochinese refugees that it has accepted).

A major problem is that while labour migration is usually determined by market forces, with flows being directed to higher income countries, and to those which require labour, refugees have often fled to some of the world's poorest countries. Difficulties of assuring asylum and arranging for resettlement of refugees are greatly increased when receiving countries already feel overpopulated, or when they have achieved a desired reduction in population growth. Thailand and Malaysia, for example, are countries that have experienced significant fertility declines, and that have been greatly concerned by the recent influx of Indochinese refugees. In other instances, the burden has fallen on countries that are the least able to absorb them. For example, Somalia's refugee population--currently estimated at 1.3 million--has increased its total population size by about one third. Pakistan, a country that encourages the emigration of its own nationals to relieve unemployment pressures, has received nearly one million refugees from Afghanistan during the past year.

The refugee problem is made more difficult by such factors as their age-sex composition. In many of those countries with the largest numbers of refugees, the camp populations are comprised almost exclusively of women, children and the elderly. A further problem is that resettlement of rural refugees is difficult in countries where land is scarce and rural underemployment is extensive, while resettlement of urban refugees is constrained by unemployment. The demographic prospects for the coming decades suggest that it will only become more difficult to resolve such situations until the principle of international burden sharing is accepted globally.

In conclusion, measured against the recommendations of the World Population Plan of Action: that Governments facilitate international freedom of movement, provide proper treatment and services for migrant workers in receiving countries, improve local conditions in sending countries, diminish the impact of the "brain drain" from developing countries, and find durable solutions for refugees, international migration policies at world level remain to be improved.

Table 1. Governments' perceptions of the demographic significance and acceptability of levels of immigration by areas of responsibility of regional commissions geographical regions and level of development. July 1978 a/

	Immigration significant			Immigration not significant		
	Too low	Satisfactory	Too high	Immigration desired	Situation satisfactory	Total.
ECA Area:						
Eastern Africa	-	2	2	-	12	16
Middle Africa	1	1	1	-	6	9
Northern Africa	-	1	1	-	4	6
Southern Africa	1	-	-	-	3	4
Western Africa	-	1	2	-	13	16
Total	2	5	6	-	38	51
ECE Area:						
Eastern Europe	-	-	-	-	6	6
Northern Europe	-	2	1	-	4	7
Southern Europe	-	-	1	-	8	9
Western Europe	-	6	2	-	1	9
Cyprus, Israel, Turkey	1	-	-	-	2	3
Northern America	-	1	1	-	-	2
USSR	-	-	-	-	3	3
Total	1	9	5	-	24	39
ECLA Area:						
Caribbean	-	-	1	-	10	11
Middle America	-	-	1	-	6	7
Temperate South America	1	-	-	-	2	3
Tropical South America	-	-	1	3	5	9
Total	1	-	3	3	23	30

Table 1. (continued)

	Immigration significant			Immigration not significant		
	Too low	Satisfactory	Too high	Immigration desired	Situation satisfactory	Total
ECWA Area:						
Western South Asia (part)	1	4	2	1	4	12
Total	1	4	2	1	4	12
ESCAP Area:						
China	-	-	-	-	1	1
Japan	-	-	-	-	1	1
Other East Asia	-	-	-	-	3	3
Eastern South Asia	-	-	2	-	7	9
Middle South Asia	-	1	2	-	6	9
Australia and New Zealand	1	-	-	-	1	2
Melanesia	-	-	-	-	2	2
Micronesia-Polynesia	-	1	1	-	4	6
Total	1	2	5	-	25	33
Developed countries	1	9	9	-	24	39
Developing countries	5	11	15	4	90	126
Total	6	20	24	4	114	165

a/ Names of countries are listed in Table A.XX.1.

Source: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table 2. Governments' policies regarding immigration by areas of responsibility of regional commissions, geographical regions and level of development. July 1980. a/

	Government policies in favour of			Emigration perceived to be not demographically significant and desirable or not desirable	Total
	higher rate	maintaining current rate	curbing emigration in future		
ECA Area:					
Eastern Africa	-	5	1	10	16
Middle Africa	-	2	-	7	9
Northern Africa	1	3	-	2	6
Southern Africa	-	2	1	1	4
Western Africa	-	3	2	11	16
Total	1	15	4	31	51
ECE Area:					
Eastern Europe	-	-	-	6	6
Northern Europe	-	-	2	5	7
Southern Europe	1	1	4	3	9
Western Europe	1	-	-	8	9
Cyprus, Israel, Turkey	1	-	1	1	3
Northern America	-	-	-	2	2
USSR	-	-	-	3	3
Total	3	1	7	28	39
ECLA Area:					
Caribbean	-	4	3	4	11
Middle America	-	2	2	3	7
Temperate South America	-	-	1	2	3
Tropical South America	-	-	4	5	9
Total	-	6	10	14	30

Table 2. (continued)

	Government policies in favour of			Emigration perceived to be not demographically significant and desirable or not desirable	Total
	higher rate	maintaining current rate	curbing emigration in future		
ECWA Area:					
Western South Asia (part)	-	2	1	9	12
Total	-	2	1	9	12
ESCAP Area:					
China	-	-	-	1	1
Japan	-	-	-	1	1
Other East Asia	1	-	-	2	3
Eastern South Asia	-	1	1	7	9
Middle South Asia	1	2	1	5	9
Australia and New Zealand	-	-	1	1	2
Melanesia	-	-	-	2	2
Micronesia-Polynesia	-	1	1	4	6
Total	2	4	4	23	33
Developed countries	2	1	7	29	39
Developing countries	4	27	19	76	126
Total	6	28	26	105	165

a/ Names of countries are listed in Table A.XX.2.

Source: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table 3. Governments' perceptions of the demographic significance and acceptability of levels of emigration by areas of responsibility of regional commissions geographical regions and level of development. July 1978 a/

	Emigration significant			Emigration not significant		
	Too low	Satisfactory	Too high	Emigration desired	Situation satisfactory	Total
ECA Area:						
Eastern Africa	-	4	2	1	9	16
Middle Africa	-	2	-	-	7	9
Northern Africa	1	3	-	-	2	6
Southern Africa	-	2	1	-	1	4
Western Africa	-	4	2	-	10	16
Total	1	15	5	1	29	51
ECE Area:						
Eastern Europe	-	-	-	-	6	6
Northern Europe	-	-	2	-	5	7
Southern Europe	1	1	4	-	3	9
Western Europe	1	-	-	-	8	9
Cyprus, Israel, Turkey	1	-	1	-	1	3
Northern America	-	-	-	-	2	2
USSR	-	-	-	-	3	3
Total	3	1	7	-	28	39
ECLA Area:						
Caribbean	-	5	2	-	4	11
Middle America	-	2	2	-	3	7
Temperate South America	-	-	1	-	2	3
Tropical South America	-	-	4	-	5	9
Total	-	7	9	-	14	30

Tabel 3. (continued)

	Emigration significant			Emigration not significant		
	Too low	Satisfactory	Too high	Emigration desired	Situation satisfactory	Total
ECWA Area:						
Western South Asia (part)	-	2	1	1	8	12
Total	-	2	1	1	8	12
ESCAP Area:						
China	-	-	-	-	1	1
Japan	-	-	-	-	1	1
Other East Asia	1	-	-	-	2	3
Eastern South Asia	-	2	-	1	6	9
Middle South Asia	1	2	1	-	5	9
Australia and New Zealand	-	-	1	-	1	2
Melanesia	-	-	-	-	2	2
Micronesia-Polynesia	-	1	1	-	4	6
Total	2	5	3	1	22	33
Developed countries	2	1	7	-	29	39
Developing countries	4	29	18	3	72	126
Total	6	30	25	3	101	165

a/ Names of countries are listed in Table A.XX.3.

Source: Compiled from United Nations Fourth Population Inquiry Among Governments in 1976 and Population Division, Population Policy Data Bank.

Table 4. Governments' policies regarding emigration by areas of responsibility of regional commissions, geographical regions and level of development. July 1980. a/

	Government policies in favour of				
	higher rate	maintaining current rate but subject to strict control	curbing immigration in future but maintaining already established immigrant population	Immigration perceived to be not demographically significant or desirable or not desirable	Total
ECA Area:					
Eastern Africa	-	3	1	12	16
Middle Africa	1	1	1	6	9
Northern Africa	-	1	1	4	6
Southern Africa	1	-	-	3	4
Western Africa	-	1	2	13	16
Total	2	6	5	38	51
ECE Area:					
Eastern Europe	-	-	-	6	6
Northern Europe	-	-	3	4	7
Southern Europe	-	-	1	8	9
Western Europe	-	-	8	1	9
Cyprus, Israel, Turkey	1	-	-	2	3
Northern America	-	2	-	-	2
USSR	-	-	-	3	3
Total	1	2	12	24	39
ECLA Area:					
Caribbean	-	1	-	10	11
Middle America	-	1	-	6	7
Temperate South America	1	-	-	2	3
Tropical South America	3	-	1	5	9
Total	4	2	1	23	30

Table 4. (continued)

	Government policies in favour of				
	higher rate	maintaining current rate but subject to strict control	curbing immigration in future but maintaining already established immigrant population	Immigration perceived to be not demographically significant or desirable or not desirable	Total
ECWA Area:					
Western South Asia (part)	1	4	2	5	12
Total	1	4	2	5	12
ESCAP Area:					
China	-	-	-	1	1
Japan	-	-	-	1	1
Other East Asia	-	-	3	5	5
Eastern South Asia	-	-	2	7	9
Middle South Asia	-	1	3	5	9
Australia and New Zealand	1	-	-	1	2
Melanesia	-	-	-	2	2
Micronesia-Polynesia	-	2	-	4	6
Total	1	3	5	24	33
Developed countries	1	2	12	24	39
Developing countries	8	15	13	90	126
Total	9	17	25	114	165

a/ Names of countries are listed in Table A.XX.4.

Source: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

ANNEX

STATISTICAL DATA: TABLES A.XVII.1 - A.XXI.4

Table A.XVII.I. Governments' perceptions of the impact of natural increase on development, its acceptability and the desirability of intervention to change rates, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980

Economic Commission for Africa

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Eastern Africa			Somalia	Madagascar Malawi			7
(B) significant			Mozambique	Zambia	Burundi Djibouti Ethiopia UR of Tanzania	Rwanda	Mauritius Seychelles Uganda	10
(C) minor						Comoros Zimbabwe	Kenya	3

Table A.XVII.1. (Continued)

Economic Commission for Africa

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) minor	No constraints	(C) minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Middle Africa				Sao Tome and Principe			1
(B) significant			Angola Congo		Chad Zaire			4
(C) minor	Central African Republic Equatorial Guinea Gabon					UR of Cameroon		4

Table A.XVII.I. (Continued)

Economic Commission for Africa

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) minor	No constraints	(C) minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Northern Africa							-
(B) significant	Libyan A. Jamahiriya				Sudan	Algeria	Morocco	4
(C) minor							Egypt Tunisia	2

Table A.XVII.I (Continued)

Economic Commission for Africa

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Southern Africa							
(B) significant							Botswana Swaziland S. Africa	3
(C) minor							Lesotho	1

Table A.XVII.I (Continued)

Economic Commission for Africa

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints: (A) predominant Higher rates desirable full intervention appropriate (1)	(B) significant some support appropriate (2)	(C) Minor (3)	Rates neither too low nor too high No constraints Neither higher nor lower rates desirable No intervention appropriate (4)	(C) Minor (5)	Rates too high Impact of constraints: (B) significant some support appropriate (6)	(A) predominant Lower rates desirable full intervention appropriate (7)	
(A) predominant	Western Africa		Benin Mali		Gambia			5
(B) significant	Guinea Ivory Coast		Guinea-Bissau	Nigeria	Cape Verde Mauritania Niger Sierra Leone Togo Upper Volta	Liberia Senegal		12
(C) minor							Ghana	1
TOTAL	6	-	6	5	17	7	10	51

Table A.XVII.I (Continued)

Economic Commission for Europe

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints: (A) predominant Higher rates desirable full intervention appropriate (1)	(B) significant some support appropriate (2)	(C) Minor (3)	Rates neither too low nor too high No constraints Neither higher nor lower rates desirable No intervention appropriate (4)	(C) Minor (5)	Rates too high Impact of constraints: (B) significant some support appropriate (6)	(A) predominant Lower rates desirable full intervention appropriate (7)	
(A) predominant	Eastern Europe		Czechoslovakia Hungary Romania	Poland				4
(B) significant	Bulgaria German D.R.							2
(C) minor								-

Table A.XVII.I (Continued)

Economic Commission for Europe

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention									Total
	Rates too low Impact of constraints:			Rates neither too low nor too high			Rates too high Impact of constraints:			
	(A) predominant	(B) significant	(C) Minor	No constraints		(C) Minor	(B) significant	(A) predominant		
	Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable			
	full intervention appropriate	some support appropriate		No intervention appropriate			some support appropriate	full intervention appropriate		
	(1)	(2)	(3)	(4)		(5)	(6)	(7)		
(A) predominant	Northern Europe		Sweden	Denmark Ireland United Kingdom						5
(B) significant			Finland Ireland	Norway						3
(C) minor										-

Table A.XVII.I (Continued)

Economic Commission for Europe

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Southern Europe		Albania Greece	Portugal Spain Yugoslavia	Italy San Marino			7
(B) significant		Holy See			Malta			2
(C) minor								

Table A.XVII.I (Continued)

Economic Commission for Europe

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints: (A) predominant	(B) significant	(C) Minor	Rates neither too low nor too high No constraints	(C) Minor	Rates too high Impact of constraints: (B) significant	(A) predominant	
	Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Western Europe		Austria					1
(B) significant		Germany F.R. of	Switzerland Belgium		Netherlands			4
(C) minor	France Liechtenstein Luxembourg Monaco							4

Table A.XVII.1 (Continued)

Economic Commission for Europe

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention									
	Rates too low			Rates neither too low nor too high			Rates too high			
	Impact of constraints:						Impact of constraints:			
	(A) predominant	(B) significant	(C) minor	No constraints		(C) Minor	(B) significant	(A) predominant		Total
	Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable			
	full intervention appropriate	some support appropriate		No intervention appropriate			some support appropriate	full intervention appropriate		
	(1)	(2)	(3)	(4)		(5)	(6)	(7)		
(A) predominant	Western South Asia (Part)									-
(B) significant		Cyprus						Turkey		2
(C) minor	Israel									1

Table A.XVII.I (Continued)

Economic Commission for Europe

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable	
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Northern America			United States				-
(B) significant					Canada			-
(C) minor								-

Table A.XVII.I (Continued)

Economic Commission for Europe

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints:			Rates neither too low nor too high		Rates too high Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Union of Soviet Socialist Republic	Byelorussian SSR Ukrainian SSR USSR						3
(B) significant								-
(C) minor								-
TOTAL	7	6	11	9	5	-	1	39

Table A.XVII.I (Continued)

Economic Commission for Latin America

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints: (A) predominant Higher rates desirable full intervention appropriate (1)	(B) significant some support appropriate (2)	(C) Minor (3)	Rates neither too low nor too high No constraints Neither higher nor lower rates desirable No intervention appropriate (4)	(C) Minor (5)	Rates too high Impact of constraints: (B) significant some support appropriate (6)	(A) predominant Lower rates desirable full intervention appropriate (7)	
(A) predominant	Caribbean				Cuba			1
(B) significant							Barbados Grenada Trinidad and Tobago	3
(C) minor						Bahamas Dominica St. Lucia St. Vincent and the Grenadines	Dominican Rep. Haiti Jamaica	7

Table A.XVII.I (Continued)

Economic Commission for Latin America

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low — Higher rates desirable			Rates neither too low nor too high — Neither higher nor lower rates desirable		Rates too high — Lower rates desirable		
	(A) predominant — full intervention appropriate (1)	(B) significant — some support appropriate (2)	(C) Minor (3)	No constraints — No intervention appropriate (4)	(C) Minor (5)	(B) significant — some support appropriate (6)	(A) predominant — full intervention appropriate (7)	
(A) predominant	Middle America							-
(B) significant					Honduras Panama	Guatemala Nicaragua	Costa Rica Mexico	6
(C) minor							El Salvador	1

Table A.XVII.I (Continued)

Economic Commission for Latin America

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention									Total
	Rates too low			Rates neither too low nor too high			Rates too high			
	Impact of constraints:						Impact of constraints:			
	(A) predominant	(B) significant	(C) Minor	No constraints		(C) Minor	(B) significant	(A) predominant		
	Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable			
	full intervention appropriate	some support appropriate		No intervention appropriate			some support appropriate	full intervention appropriate		
	(1)	(2)	(3)	(4)		(5)	(6)	(7)		
(A) predominant	Temperate S. America	Chile								1
(B) significant										-
(C) minor	Argentina Uruguay									2

Table A.XVII.I (Continued)

Economic Commission for Latin America

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints:			Rates neither too low nor too high		Rates too high Impact of constraints:		
	(A) predominant	(B) significant	(C) minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Tropical S. America			Brazil				1
(B) significant		Paraguay	Ecuador	Guyana	Colombia Venezuela	Peru		6
(C) minor	Bolivia				Surinam			2
TOTAL	3	2	1	2	6	7	9	30

Table A.XVII.I (Continued)

Economic Commission for Western Asia

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) minor	No constraints	(C) minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Western Asia	Kuwait	Iraq	Bahrain				5
(B) significant	Qatar Oman Saudi Arabia United Arab Emirates				Dem. Yemen Jordan Lebanon Syrian Arab Rep. Yemen			9
(C) minor								-
TOTAL	4	1	1	1	5	-	-	12

Table A.XVII.I (Continued)

Economic Commission for Asia and the Pacific

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	China							-
(B) significant							China	1
(C) minor								-

Table A.XVII.I (Continued)

Economic Commission for Asia and the Pacific

Governments perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Japan							-
(B) significant					Japan			1
(C) minor								-

Table A.XVII.I (Continued)

Economic Commission for Asia and the Pacific

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Other East Asia							-
(B) significant	D.P.R. of Korea, Mongolia						Rep. of Korea	5
(C) minor								-

Table A.XVII.I (Continued)

Economic Commission for Asia and the Pacific

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention								Total
	Rates too low			Rates neither too low nor too high		Rates too high			
	Impact of constraints:					Impact of constraints:			
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant		
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable			
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)		
(A) predominant	Eastern South Asia		Singapore	Burma					7
(B) significant	Democratic Kampuchea Lao P.D. Rep.				Malaysia		Indonesia Philippines Socialist Rep. of Viet Nam		6
(C) minor							Thailand		1

Table A.XVII.I (Continued)

Economic Commission for Asia and the Pacific

Governments perceptions of the impact of natural increase as a positive contribution to development	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints:			Rates neither too low nor too high		Rates too high Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable	
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Middle South Asia			Maldives				1
(B) significant		Bhutan			Afghanistan		Iran	3
(C) minor							Bangladesh India Nepal Pakistan Sri Lanka	5

Table A.XVII.I (Continued)

Economic Commission for Asia and the Pacific

Governments perceptions of the impact of natural increase as a positive contribution to development	Governments perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low			Rates neither too low nor too high		Rates too high		
	Impact of constraints:					Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Australia and New Zealand		Australia					1
(B) significant					New Zealand			1
(C) minor								-

Table A.XVII.I (Continued)

Economic Commission for Asia and the Pacific

	Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints:			Rates neither too low nor too high		Rates too high Impact of constraints:		
	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Melanesia							-
(B) significant						Solomon Islands	Papua New Guinea	2
(C) minor								-

Governments' perceptions of the impact of natural increase as a positive contribution to development	Governments perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
	Rates too low Impact of constraints: (A) predominant	(B) significant	(C) Minor	Rates neither too low nor too high No constraints	(C) Minor	Rates too high Impact of constraints: (B) significant	(A) predominant	
	Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable	
	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
(A) predominant	Micronesia-Polynesia							-
(B) significant	Nauru					Kiribati Tuvalu	Fiji Tonga	5
(C) minor							Samoa	1
TOTAL	5	1	2	2	4	3	16	33
Developed countries	6	5	12	9	7	-	-	39
Developing countries	19	5	9	8	30	17	38	126
TOTAL	25	10	21	17	37	17	38	165

Source: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XVII.2 Combinations of policy options selected by Governments to solve problems associated with natural increase, by perception of the effect of natural increase on development, its acceptability and the desirability of intervention to change it, by areas of responsibility of regional commissions and geographical regions, July 1980

	Policy options[a]					Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							
						Rates too low			Rates neither too low nor too high			Rates too high	
						Impact of constraints:						Impact of constraints:	
	Mortality	Fertility	Spatial distribution	International migration	Technology and organization	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	Total
						Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable	
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Eastern Africa						Area of responsibility of Economic Commission for Africa							
Burundi	.	.	x	.	x					x			
Comoros	.	.	-	x	x						x		
Djibouti	-	.	x	x	x					x			
Ethiopia	.	.	x	.	x					x			
Kenya	.	-	x	.	x							x	
Madagascar	.	.	x	.	x					x			
Malawi	.	.	x	x	x					x			
Mauritius	.	-	x	x	x							x	
Mozambique	-	=	x	x	x			x					
Rwanda	.	.	-	.	x						x		
Seychelles	.	-	x	x	x							x	
Somalia	.	.	x	x	.				x				
Uganda	.	-	x	x	x							x	
United Republic of Tanzania	.	.	x	.	x					x			
Zambia	.	.	x	.	x				x				
Zimbabwe b/			x	x							x		
Middle Africa													
Angola	-	.	x	x	x			x					
Central African Republic	-	.	x	.	x	x							
Chad	.	.	-	x	x					x			
Congo	.	.	x	.	x			x					
Equatorial Guinea	-	.	x	x	x	x							
Gabon	-	+	x	x	x	x							
Sao Tome and Principe	.	.	x	.	x					x			
United Republic of Cameroon	-	.	x	.	x						x		
Zaire	-	.	x	x	x								

Table A.XVII.2 (Continued)

	Policy options[a]					Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organisation	(A) predominant	(B) significant	(C) Minor	No constraints	(C') Minor	(B) significant	(A) predominant	
						Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Northern Africa													
Algeria	.	.	x	x	.						x		
Egypt	.	-	x	x	x							x	
Libyan Arab Jamahiriya	-	+	x	x	x	x							
Morocco	.	-	x	x	x							x	
Sudan	-	.	x	x	x					x			
Tunisia	.	-	x	x	x							x	
Southern Africa													
Botswana	.	-	x	x	x							x	1
Lesotho	.	-	-	x	x							x	
South Africa	.	-	x	x	x							x	
Swaziland	.	-	x	x	x							x	
Western Africa (continued)													
Benin	.	=	x	.	.			x					
Cape Verde	.	.	-	.	x					x			
Gambia	.	.	x	.	x					x			
Ghana	.	-	x	x	x							x	
Guinea	-	+	-	x	x	x							
Guinea-Bissau	-	.	x	.	x			x					
Ivory Coast	-	=	x	x	x	x					x		
Liberia	.	.	x	x	x								
Mali	.	=	x	.	.			x					
Mauritania	.	.	x	x	x					x			
Niger	.	=	-	.	x					x			

Table A.XVII.2 (Continued)

	Policy options[a]					Governments perceptions of the impact of natural increase as a constraint on development and desirability of intervention							
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organisation	(A) predominant	(B) significant	(C) minor	No constraints	(C) minor	(B) significant	(A) predominant	Total
						Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Nigeria	.	.	x	.	x				x				
Senegal	.	.	x	x	x					x			
Sierra Leone	.	.	x	.	x						x		
Togo	.	x	x	.	x					x			
Upper Volta	.	x	x	x	x					x			
		Total:				6	-	6	3	17	7	12	51

Table A.XVII.2 (Continued)

	Policy options[a]					Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
						(A) predominant	(B) significant	(C) Minor	No constraints	Minor	(B) significant	(A) predominant	
						Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
	Mortality	Fertility	Spatial distribution	International migration	Technology and organisation	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Eastern Europe						Area of responsibility of Economic Commission for Europe							
Bulgaria	-	+	x	.	x	x							
Czechoslovakia	.	=	x	.	.			x					
German Democratic Republic	.	+	x	.	x	x							
Hungary	.	=	x	.	.			x					
Poland	.	.	x	.	.				x				
Romania	.	=	x	.	.			x					
Northern Europe													
Denmark	.	.	-	.	.				x				
Finland	-	=	x	x	x			x					
Iceland	.	.	x	.	.				x				
Ireland	.	=	x	x	x			x					
Norway	.	.	x	x	.				x				
Sweden	.	.	x	x	.			x					
United Kingdom	.	.	x	x	.				x				
Southern Europe													
Albania	-	=	x	.	x			x					
Greece	-	+	x	x	x			x					
Holy See	.	.	-	.	x		x						
Italy	.	.	x	x	x					x			
Malta	.	.	-	x	x					x			
Portugal	.	.	x	x	.				x				
San Marino	.	.	-	x	.					x			
Spain	.	.	x	x	.				x				
Yugoslavia	.	.	x	x	.				x				

Table A.XVII.2 (Continued)

	Policy options[a]					Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							
						Rates too low			Rates neither too low nor too high			Rates too high	
						Impact of constraints:					Impact of constraints:		
						(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	Total
						Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organisation	full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Western Europe													
Austria	.	.	x	x	.			x					
Belgium	.	=	-	.	.			x					
France	-	+	x	x	x	x							
Germany, Federal Republic of	.	.	x	x	x		x						
Liechtenstein	.	+	-	x	x	x							
Luxembourg	.	+	-	x	x	x							
Monaco	.	+	-	x	x	x							
Netherlands	.	.	x	x	x					x			
Switzerland	.	.	x	x	x			x					
Western South Asia (part)													
Cyprus	.	.	x	x	x		x						
Israel	-	+	x	x	x	x						x	
Turkey	.	-	x	x	x								
Northern America													
Canada	.	.	-	x	x					x			
United States of America	.	.	-	x	.				x				
Union of Soviet Socialist Republics													
Byelorussian SSR	.	=	x	.	x		x						
Ukrainian SSR	-	=	x	.	x		x						
USSR	-	=	x	.	x		x						
Total:						7	6	11	9	5		1	39

Table A.XVII.2 (Continued)

	Policy options[a]					Governments perceptions of the impact of natural increase as a constraint on development and desirability of intervention							
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organization	(A) predominant	(B) significant	(C) minor	No constraints	Minor	(B) significant	(A) predominant	Total
						Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Area of responsibility of Economic Commission for Latin America													
Caribbean													
Bahamas	.	.	x	x	x						x		
Barbados	.	-	-	x	x							x	
Cuba	.	.	x	x	.					x			
Dominica b/		-	-	.							x		
Dominican Republic	.	.	-	x	x							x	
Grenada	.	-	x	x	x							x	
Haiti	.	-	x	x	x							x	
Jamaica	.	-	x	x	x						x		
Saint Lucia b/		-	-	.							x		
Saint Vincent and the Grenadines b/		-	-	.								x	
Trinidad and Tobago	.	-	x	x	x								
Middle America												x	
Costa Rica	.	-	x	x	x							x	
El Salvador	.	-	x	x	x						x		
Guatemala	.	.	x	.	x					x			
Honduras	.	.	-	x	x						x	x	
Mexico	.	-	x	x	x								
Nicaragua	.	.	x	x	x					x			
Panama	.	.	x	.	x								
Temperate South America													
Argentina	-	+	x	x	x	x							
Chile	.	.	x	.	.								
Uruguay	-	+	x	x	x	x							

Table A.XVII.2 (Continued)

	Policy options[a]					Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organization	(A) predominant	(B) significant	(C) minor	No constraints	(C) minor	(B) significant	(A) predominant	Total
						Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Tropical South America													
Bolivia	-	+	x	x	x	x							
Brazil	.	.	x	.	.				x				
Colombia	.	+	x	x	x					x			
Ecuador	.	.	x	x	x			x					
Guyana	.	.	x	x	.								
Paraguay	-	.	x	x	x				x				
Peru	.	.	x	.	x		x						
Suriname	.	.	x	x	x						x		
Venezuela	.	.	x	x	x					x			
		Total:				3	2	1	2	6	7	9	30

Table A.XVII.2 (Continued)

	Policy options[a]					Governments' perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organisation	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
						Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable	
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Area of responsibility of Economic Commission for Western Asia													
Western South Asia													
Bahrain	.	.	-	x	.				x				
Democratic Yemen	.	.	x	x	x					x			
Iraq	-	+	x	.	x			x					
Jordan	.	-	x	x	x					x			
Kuwait	.	=	-	x	x		x						
Lebanon	.	.	x	x	x					x			
Oman	-	=	x	x	x	x							
Qatar	-	=	-	x	x	x							
Saudi Arabia	-	=	x	x	x	x							1
Syrian Arab Republic	.	.	x	.	x					x			
United Arab Emirates	-	=	x	x	x	x							
Yemen	.	.	-	x	x					x			
		Total:				4	1	1	1	5			12

Table A.XVII.2 (Continued)

	Policy options[a]					Governments perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organisation	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
						Higher rates desirable			Neither higher nor lower rates desirable			Lower rates desirable	
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Area of responsibility of Economic and Social Commission for Asia and the Pacific													
China													
China	.	-	x	.	x							x	
Japan													
Japan	.	.	x	.	.					x			
Other East Asia													
Democratic People's Republic of Korea	-	=	x	.	x	x							
Mongolia	-	=	x	.	x	x							
Republic of Korea	.	-	x	x	x							x	
Eastern South Asia													
Burma	.	.	x	.	.				x				
Democratic Kampuchea	-	+	x	x	x	x							
Indonesia	.	-	x	.	x							x	
Lao People's Democratic Republic	-	+	x	.	x	x							
Malaysia	.	=	x	x	x					x			
Philippines	.	-	x	.	x							x	
Singapore	.	=	=	.	.			x					
Thailand	.	-	x	x	x							x	
Viet Nam	.	-	x	x	x							x	

Table A.XVII.2 (Continued)

	Policy options[a]					Governments perceptions of the impact of natural increase as a constraint on development and desirability of intervention							Total
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organisation	(A) predominant	(B) significant	(C) Minor	No constraints	(C) Minor	(B) significant	(A) predominant	
						Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
						full intervention appropriate	some support appropriate		No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Middle South Asia													
Afghanistan	.	.	x	x	x					x			
Bangladesh	.	-	x	.	x							x	
Bhutan	-	.	x	x	x		x						
India	.	-	x	.	x							x	
Iran	.	-	x	x	x							x	
Maldives	.	.	x	.	.				x				
Pakistan	.	-	x	x	x							x	
Nepal	.	-	x	x	x							x	
Sri Lanka	.	-	x	x	x							x	
Australia and New Zealand													
Australia	.	.	x	x	x			x					
New Zealand	.	.	-	x	x					x			
Melanesia													
Papua New Guinea	.	-	-	.	x							x	
Solomon Islands b/		.	-	.							x		

Table A.XVII.2 (Continued)

	Policy options[a]					Governments perceptions of the impact of natural increase as a constraint on development and desirability of intervention							
						Rates too low			Rates neither too low nor too high		Rates too high		
						Impact of constraints:					Impact of constraints:		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organization	(A) predominant	(B) significant	(C) Minor	No constraints	Minor	(B) significant	(A) predominant	Total
						Higher rates desirable			Neither higher nor lower rates desirable		Lower rates desirable		
						full intervention appropriate		some support appropriate	No intervention appropriate		some support appropriate	full intervention appropriate	
						(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Micronesia-Polynesia													
Fiji	.	-	x	x	x							x	
Kiribati b/	.	=	x	.	x						x		
Nauru	.	=	-	x	.	x							
Samoa	.	-	-	x	x							x	
Tonga	.	-	x	x	x							x	
Tuvalu b/		.	x	.							x		
	Total:					5	1	2	2	4	5	16	35

[a] Key:
Policy options for mortality and fertility
+ Increase (e.g. "+" in the fertility column indicates that the Government has a policy of increasing fertility)
- Decrease
= Maintain at current levels in the face of probable decrease if no intervention occurred
. No intervention
Policy options for spatial distribution, international migration and technology and organization
x Intervention
. No intervention

b/ Countries which became independent during the period 1976-1980 have not yet officially stated all aspects of their population policies

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1976 and Population Division, Population Policy Data Bank

Table A.XVIII.I. Average life expectancy at birth, 1975-1979, and Governments' perceptions of its acceptability in prevailing economic and social circumstances, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980

Geographical region and country	Under 50 years		50 - 61 years		62[a] - 69 years		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Area of responsibility of the Economic Commission for Africa											
Eastern Africa	Rwanda	Burundi Comoros Djibouti Ethiopia Madagascar Malawi Mozambique Somalia Zambia	Kenya Uganda U.R. of Tanzania		Seychelles	Mauritius			2	13	15
Middle Africa		Angola Central African Rep. Chad Congo Equatorial Guinea Gabon Sao Tome and Principe U.R. of Cameroon Zaire							-	9	9
Northern Africa		Sudan	Algeria Egypt Libyan Arab Jamahiriya Morocco Tunisia						-	6	6

Table A.XVIII.I (Continued)

Geographical region and country	Under 50 years		50 - 61 years		62[a/] - 69 years		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Southern Africa		Botswana Swaziland		Lesotho South Africa Zimbabwe					-	5	5
Western Africa		Benin Gambia Ghana Guinea Guinea Bissau Ivory Coast Liberia Mali Mauritania Niger Nigeria Senegal Sierra Leone Togo Upper Volta		Cape Verde					-	16	16
	1	36	-	12	1	1	-	-	2	49	51

Table A.XVIII.I. (Continued)

Geographical region and country	Under 50 years		50 - 61 years		62 a/ - 69 years		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Area of responsibility of the Economic Commission for Europe											
Eastern Europe					Hungary		Bulgaria Czechoslovakia German Dem. Republic Poland Romania		6	-	6
Northern Europe							Denmark Iceland Ireland Norway Sweden	Finland United Kingdom	5	2	7
Southern Europe					Portugal	Albania Yugoslavia	Greece Holy See Malta San Marino Spain	Italy	6	3	9
Western Europe							Austria Belgium Germany F. R. of Liechtenstein Luxembourg Monaco Netherlands Switzerland	France b/	8	1	9

Table A.XVIII.I (Continued)

Geographical region and country	Under 50 years		50 - 61 years		62 - 69 years [a/]		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Western South Asia (part)				Turkey			Cyprus Israel		2	1	3
North America							Canada United States		2	-	2
Union of Soviet Socialist Republics								Byelorussian SSR Ukrainian SSR USSR	-	3	3
	-	-	-	1	2	2	27	7	29	10	39

b/ In its reply to the Third United Nations Population Inquiry the Government of France noted that, whereas it considered that levels of average life expectancy for females were acceptable in prevailing economic and social circumstances, those for males were not considered acceptable.

Table A.XVIII.I (Continued)

Geographical region and country	Under 50 years		50 - 61 years		62 - 69 years [a]		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Area of responsibility of the Economic Commission for Latin America											
Caribbean			Dominican Republic	Haiti	Trinidad + Tobago	Bahamas Dominica Grenada Saint Lucia Saint Vincent + The Grenadines	Barbados Cuba Jamaica		5	6	11
Middle America				Guatemala Honduras Nicaragua	Costa Rica Panama	El Salvador Mexico			2	5	7
Temperate South America					Chile Uruguay	Argentine			2	1	3
Tropical South America			Ecuador	Bolivia Peru	Guyana	Brazil Colombia Paraguay Suriname Venezuela			2	7	9
	-	-	2	6	6	13	3	-	11	19	30

Table A.XVIII.I (Continued)

Geographical region and country	Under 50 years		50 - 61 years		62 a/ - 69 years		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Area of responsibility of the Economic Commission for Western Asia											
Western South Asia											
	Dem.Yemen, Oman, Saudi Arabia, Yemen		Iraq, Jordan, Qatar, Syrian A.R.		Kuwait, United Arab Emirates	Bahrain, Lebanon					
	-	4	4	-	2	2	-	-	6	6	12

Table A.XVIII.I (Continued)

Geographical region and country	Under 50 years		50 - 61 years		62 - 69 years [a]		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Area of responsibility of the Economic and Social Commission for Asia and the Pacific											
China						China			-	1	1
Japan							Japan		1	-	1
Other East Asia					R. of Korea	D.P.R. of Korea Mongolia			1	2	3
Eastern South Asia	Democratic Kampuchea Lao P.D.R S.R. of Viet Nam	Malaysia Philip-pines	Burma Indonesia Thailand		Singapore				3	6	9
Middle South Asia	Afghanis-tan Bangladesh Bhutan Maldives Nepal		India Iran Pakistan		Sri Lanka				1	8	9
Australia and New Zealand							Australia New Zealand		2	-	2

Table A.XVIII.I (Continued)

Geographical region and country	Under 50 years		50 - 61 years		62[a] - 69 years		70 years and over		All ages		Total
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	
Melanesia		Papua New Guinea		Solomon Islands					-	2	2
Micronesia-Polynesia						Kiribati Tonga Samoa Tuvalu		Fiji Nauru	2	4	6
	-	9	2	7	3	7	5	-	10	23	33
Developed countries	28	7	2	2	-	-	-	-	30	9	39
Developing countries	7	-	12	23	8	26	1	49	28	98	126
Total	35	7	14	25	8	26	1	49	58	107	165

a/ A life expectancy at birth of 62 years corresponds to the average world life expectancy by 1985 referred to in paragraph 22 of the World Population Plan of Action. The other categories in this table were chosen in reference to this figure.

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XIX.1 Governments' perceptions and policies with respect to national fertility and to access to effective fertility regulation, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980. a/

Governments' perceptions of the acceptability of current fertility and of the desirablity of intervention to change it						Total
Rates not satisfactory too low; higher rates desirable		Rates satisfactory		Rates not satisfactory too high; lower rates desirable		
Intervention to raise rates appropriate and incentives and disincentives implemented	Intervention not appropriate. Neither incentives nor disincentives implemented	But incentives and disincentives implemented to maintain rates	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention not appropriate Neither incentives nor disincentives implemented	Intervention to lower rates appropriate and incentives and disincentives implemented	
I	II	III	IV	V	VI	
Area of responsibility of the Economic Commission for Africa						
Eastern Africa		Mozambique (4)	Burundi (2) Ethiopia (3) Malawi (1) Somalia (2) U.R. of Tanzania (4) Zambia (4)	Comoros (2) Djibouti (3) Madagascar (3) Rwanda (4) Zimbabwe (4)	Kenya (4) Mauritius (4) Seychelles (4) Uganda (4)	16
Middle Africa						
Gabon (1)	Equato. Guinea (1) Cen. African Rep. (2)		Angola (3) Chad b/ (1) Congo (4) Sao Tome and Principe (2) Zaire (4)	United Rep. of Cameroon (3)		9

Table A.XIX.1 (Continued)

I	II	III	IV	V	VI	Total
Northern Africa						
Libyan Arab Jamahiriya (1)			Sudan (4)	Algeria (4)	Egypt (4) Morocco (4) Tunisia (4)	6
Southern Africa					Botswana (4) Lesotho (4) South Africa (4) Swaziland (4)	4
Western Africa						
Guinea (2)		Benin (2) Ivory Coast (2) Mali (4) Mauritania (2) Niger (2) Togo (3) Upper Volta (2)	Cape Verde (4) Gambia (3) Guinea-Bissau (3) Nigeria (3)	Liberia (4) Sierra Leone (3) Senegal (4)	Ghana (4)	16
Total 3	2	8	16	10	12	51

Table A.XIX.1 (Continued)

Governments' perceptions of the acceptability of current fertility and of the desirability of intervention to change it						
Rates not satisfactory too low: higher rates desirable		Rates satisfactory		Rates not satisfactory too high: lower rates desirable		
Intervention to raise rates appropriate and incentives and disincentives	Intervention not appropriate. Neither incentives not disincentives implemented	But incentives and disincentives implemented to maintain rates	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention to lower rates appropriate and incentives and disincentives implemented	Total
I	II	III	IV	V	VI	
Area of responsibility of the Economic Commission for Europe						
Eastern Europe						
Bulgaria (4) German. D.R. (4)		Czechoslovakia (4) Hungary (4) Romania (4)	Poland (4)			6
Northern Europe		Finland (4) Ireland (2)	Denmark (4) Iceland (4) Norway (4) Sweden (4) United Kingdom (4)			7
Southern Europe						
Greece (2)		Albania (4)	Holy See (1) Italy (3) Malta (1) Portugal (4) San Marino (2) Spain (3) Yugoslavia (4)			9

Table A.XIX.1 (Continued)

I	II	III	IV	V	VI	Total
Western Europe France (4) Liechtenstein (2) Luxembourg (3) Monaco (4)	Germany, F.R.of (3)	Belgium (3)	Austria (4) Netherlands (3) Switzerland (3)			9
Western South Asia (part) Israel (4)	Cyprus (2)				Turkey (4)	3
Northern America			Canada (4) United States (4)			2
Union of Soviet Socialist Republics		Byelorussian SSR(4) Ukrainian SSR (4) U.S.S.R. (4)				3
Total 8	2	10	18	-	1	39

Table A.XIX.1 (Continued)

Governments' perceptions of the acceptability of current fertility and of the desirability of intervention to change it						
Rates not satisfactory too low: higher rates desirable		Rates satisfactory		Rates not satisfactory too high: lower rates desirable		
Intervention to raise rates appropriate and incentives and disincentives	Intervention not appropriate. Neither incentives not disincentives implemented	But incentives and disincentives implemented to maintain rates	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention to lower rates appropriate and incentives and disincentives implemented	Total
I	II	III	IV	V	VI	
Area of responsibility of the Economic Commission for Latin America						
Caribbean			Cuba (4)	Bahamas (3) Dominican Rep. (4) St. Lucia (4) St. Vincent and the Grenadines (4)	Barbados (4) Dominica (4) Grenada (4) Haiti (4) Jamaica (4) Trinidad and Tobago (4)	11
Middle America		Panama (4)	Honduras (4)	Guatemala (4) Nicaragua b/ (4)	Costa Rica (4) El Salvador (4) Mexico (4)	7
Temperate South America						
Argentina (2) Uruguay (1)	Chile (4)					3

Table A.XIK.1 (Continued)

I	II	III	IV	V	VI	Total
Tropical South America Bolivia (2)		Colombia (4)	Ecuador (4) Brazil (4) Guyana (2) Peru c/ (4) Surinam (2) Venezuela (4) Paraguay (4)			9
Total 3	1	2	9	6	9	30

c/ Recently changed its policies with respect to provision of support for effective individual fertility regulation and it is now in Category 3.

Table A.XIX.1 (Continued)

Governments' perceptions of the acceptability of current fertility and of the desirability of intervention to change it						
Rates not satisfactory too low: higher rates desirable		Rates satisfactory		Rates not satisfactory too high: lower rates desirable		Total
Intervention to raise rates appropriate and incentives and disincentives	Intervention not appropriate. Neither incentives not disincentives implemented	But incentives and disincentives implemented to maintain rates	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention to lower rates appropriate and incentives and disincentives implemented	
I	II	III	IV	V	VI	
Area of responsibility of the Economic and Social Commission for Western Asia						
Western Asia						
Iraq (2)		Kuwait (2) Oman (2) Qatar (2) Saudi Arabia (1) United Arab Emirates (2)	Democratic Yemen (4) Lebanon (3) Syrian A.R. (4) Yemen (4)	Bahrain (3) Jordan (4)		12
Total 1	-	5	4	2	-	12

Table A.X.X.1 (Continued)

Governments' perceptions of the acceptability of current fertility and of the desirability of intervention to change it						
Rates not satisfactory too low: higher rates desirable		Rates satisfactory		Rates not satisfactory too high: lower rates desirable		
Intervention to raise rates appropriate and incentives and disincentives	Intervention not appropriate. Neither incentives not disincentives implemented	But incentives and disincentives implemented to maintain rates	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention not appropriate. Neither incentives nor disincentives implemented	Intervention to lower rates appropriate and incentives and disincentives implemented	Total
I	II	III	IV	V	VI	
Area of responsibility of the Economic and Social Commission for Asia and the Pacific						
China					China (4)	1
Japan			Japan (4)			1
Other East Asia		D.P.R. Korea (4) Mongolia (4)			Rep. of Korea (4)	3
Eastern South Asia						
b/ Dem. Kampuchea (1) Lao People's Dem. Republic (1)		Singapore (4) Malaysia (4)	Burma (2)		Indonesia (4) Philippines (4) SR of Viet Nam (4) Thailand (4)	9
Middle S. Asia			Bhutan (4) Maldives (2)	Afghanistan b/ (4)	Bangladesh (4) India (4) Iran b/ (4) Pakistan (4) Nepal (4) Sri Lanka (4)	9

Table A.XIX.1 (Continued)

I		II	III	IV	V	VI	Total
Australia and New Zealand				Australia (4) New Zealand (4)			2
Melanesia					Solomon Islands (4)	Papua New Guinea (4)	2
Micronesia-Polynesia			Nauru (4) Kiribati (4)		Tuvalu (4)	Fiji (4) Tonga (4) Samoa (4)	6
Total	2	-	6	6	3	15	33
Developed countries	7	1	10	21	-	-	39
Developing countries	10	4	21	32	21	33	126
Total	17	5	31	53	21	33	165

a/ Numbers in brackets refer to Governments' policies with respect to provision of support for effective individual fertility regulation:

1) access limited;
2) access not limited, but no support provided;
3) access not limited and indirect support provided;
4) access not limited and direct support provided.

b/ The perception and policies are those prevailing as of the last monitoring

- Nicaragua
- Democratic Kampuchea
- Iran
- Afghanistan
- Chad

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XIX.2. Governments' policies with respect to effective use of modern methods of fertility regulation, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980 a/

Area of responsibility of the Economic Commission for Africa

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
Eastern Africa	Malawi	Burundi Comoros Somalia	Djibouti Ethiopia Madagascar	Kenya Mauritius Mozambique Rwanda (2) Seychelles Uganda U.R. of Tanzania Zambia Zimbabwe	16
Middle Africa	Chad Equatorial Guinea Gabon	Cen. Afr. Rep. Sao Tome and Principe	Angola U.R. of Cameroon	Congo Zaire	9
Northern Africa	Libyan Arab Jamahiriya			Algeria Egypt Morocco Sudan Tunisia	6

a/ Countries underlined are those whose Governments have changed their policy concerning access to modern methods of contraception between 1 July 1978 and 1 July 1980. Figure in brackets refers to situation as 1 July 1978.

Table A.XIX.2 (Continued)

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
Southern Africa				Botswana Lesotho South Africa Swaziland	4
Western Africa		Benin Guinea Ivory Coast Mauritania Niger Upper Volta	Gambia Guinea-Bissau Nigeria Sierra Leone Togo	Cape Verde Ghana Liberia Mali Senegal	16
Total	5	11	10	25	51

Table A.XIX.2. (Continued)

Area of responsibility of the Economic Commission for Europe

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
Eastern Europe				Bulgaria Czechoslovakia German Dem. Rep. Hungary Poland Romania	6
Northern Europe		Ireland (1)		Denmark Finland Iceland Norway Sweden United Kingdom	7
Southern Europe	Greece b/ Holy See Malta	San Marino	Italy Spain (2)	Albania Portugal Yugoslavia	9
Western Europe		Liechtenstein	Belgium Germany, Fed.Rep. of Luxembourg Netherlands Switzerland	Austria France Monaco	9

b/ Greece changed its policies with regard to limitation of access to effective individual fertility regulation and it is now in Category 2.

Table A.XIX.2 (Continued)

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
Western South Asia (part)		Cyprus		Israel Turkey	3
Northern America				Canada United States	2
Union of Soviet Socialist Republics				Byelorussian SSR Ukrainian SSR USSR	3
Total	3	4	7	25	39

Table A.XIX.2 (Continued)

Area of responsibility of the Economic Commission for Latin America

Region	Access limited (1)	Access not limited			
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	Total
Caribbean			Bahamas	Barbados Cuba Dominica Dominican Republic Grenada Haiti Jamaica Saint Lucia Saint Vincent and the Grenadines Trinidad and Tobago	11

Table A.XIX.2 (Continued)

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
Middle America				Costa Rica El Salvador Guatemala Honduras Mexico Nicaragua Panama	7
Temperate South America	Uruguay	Argentina		Chile	3
Tropical South America		Bolivia Guyana Surinam		Brazil Colombia Ecuador Paraguay Peru c/ Venezuela	9
Total	1	4	1	24	30

c/ Recently changed its policies with regard to provision of support for effective individual fertility regulation and it is now in Category 3.

Table A.XIX.2 (Continued)

Area of responsibility of the Economic Commission for Western Asia

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
Western Asia	Saudi Arabia	Iraq Kuwait Oman Qatar United Arab Emirates	Bahrain Lebanon	Democratic Yemen Jordan Syrian Arab Republic Yemen	12
Total	1	5	2	4	12

Table A.XIX.2 (Continued)

Area of responsibility of the Economic and Social Commission for Asia and the Pacific

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
China				China	1
Japan				Japan	1
Other Eastern Asia				Dem. People's Republic of Korea Mongolia Republic of Korea	3
Eastern South Asia	Dem. Kampuchea Lao P.D.R.	Burma		Indonesia Malaysia Philippines Singapore Socialist Republic of Viet Nam Thailand	9

Table A.XIX.2 (Continued)

Region	Access limited (1)	Access not limited			Total
		No support provided (2)	Indirect support provided (3)	Direct support provided (4)	
Middle South Asia		Maldives		Afghanistan Bangladesh Bhutan India Iran a/ Nepal Pakistan Sri Lanka	
Australia and New Zealand			Australia	New Zealand	
Melanesia				Papua New Guinea Salomon Islands	
Micronesia-Polynesia				Fiji Kiribati Nauru Samoa Tonga Tuvalu	
Total	2	2	1	28	
Developed Countries	3	3	8	25	
Developing countries	9	23	13	81	
TOTAL	12	26	21	106	

a/ Following the most recent information, access to effective use of modern methods of fertility regulation is still permitted, but all voluntary organizations are now transferred to the various Governments departments.

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XIX.3. Legal status and grounds for granting an abortion by areas of responsibility of regional commissions and geographical regions, July 1980

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for [b]			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Area of responsibility of the Economic Commission for Africa															
Eastern Africa															
Burundi				Life (in practice)								I, 2 to 10 Y	I,2 to 5 Y		
Comoros		No information													
Djibouti		No information													
Ethiopia	1957			-Life -Health		Rape and incest operate only as extenuating factors in sentencing			-Woman's consent required -If unable for health reasons, her next of kin or her legal representative may consent on her behalf	Performing physician and another doctor, specialist in the disease endangering health, life of the mother, must give authorization		I, up to 5 Y	I, 3 M to 5 Y		

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Kenya	1972			Life								I, up to 14 Y	I, up to 7 Y	I, up to 3 Y	
Madagascar	1962			Life								I, 1 to 5 Y and fine	I, 6 M to 2 Y and fine		
Malawi	1968			Life								I, up to 14 Y	I, up to 7 Y	I, up to 3 Y	
Mauritius	1945			Life								-I, up to 10 Y -Medical personnel harsher penalties	I, up to 10 Y	I, up to 10 Y	

Table A.XIX.5 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Mozambique				Life								I, 2 to 8 Y	-I, 2 to 8 Y -Less severe penalty if offense committed in order to conceal her dishonor		Law in force until independence. No information on the present legal situation
Rwanda	1970			Life (in practice)								Penal servitude 2 to 10 Y	Penal servitude 2 to 5 Y		
Seychelles				Life											

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Somalia	1962			Life								- I, 1 to 5 Y - Medical personnel harsher penalties	I, 1 to 5 Y	I, 6 M to 2 Y	
Uganda	1964			-Life -Physical health. -Mental health						Approval of two medical practitioners required in practice		I, for 14 Y	I, for 7 Y		
U.R. of Tanzania				-Life -Health		Mother suffering from some severe psychiatric illness				Approval of two attending physicians required.		I, for 14 Y	I, for 7 Y	I, for 3 Y	

Table A.XIX.5 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Zambia	1972		Risk of injury to the physical or mental health of any existing children	-Life -Physical health. -Mental health	Serious risk of physical or mental abnormalities		The pregnant woman's actual or reasonably foreseeable environment and age taken in account in determining any abortion			Approval of medical practitioner performing abortion and of two others required, unless emergency.	In government or approved hospitals unless emergency.	I. for 14 Y		I. for 7 Y	
Zimbabwe	1978			Physical health	Danger of serious physical or mental impairment of the fetus.	Unlawful intercourse.									

Table A.XIX.3 (Continued)

Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities		Penalties for			Remarks
	On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
			Life								I, 2 to 8 Y	-I, 2 to 8 Y -Less severe penalty if offense committed in order to conceal her dishonor.		Law in force until independence. No information on the present legal situation
1961			Life (in practice)								I, 1 to 5 Y and/or fine	I, 6 M to 2 Y and/or fine		

Table A.XIX.3 (Continued)

Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
	On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
1967			Life						Performing physician needs attested written approval of two other physicians, one of whom must be an expert on the list of the Civil Court		-I, 1 to 5 Y and fine -If foregoing is habitual I, 5 to 10 Y -Harsher penalties for medical personnel same as above and in addition, suspension from professional practice, 5 Y to life	I, 2 M to 2 Y and fine.		

Table A.XIX.3 (Continued)

Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
	On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
1810		In practice permissible in cases where the birth of a child would result in socio-economic hardship on the mother or family.	-Life -Health						-For health reasons, a committee of physicians has to examine each case individually. -For socio-economic reasons, recommendation of a social worker needed.					-Abortion performed frequently -New law pertaining to the subject currently drawn

No information

Table A.XIX.3 (Continued)

Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
	On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
1963			Life								-I, 1 to 5 Y and fine -Harsher penalties for medical personnel	-I, 6 M to 2 Y and fine		
No information														

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
on	1967			Health		Rape				-Performer must be a qualified medical person and approval of two consultant physicians required. -Abortion on juridical ground requires verification by the public prosecutor's office.		I, 1 to 5 Y and fine -Harsher penalties for physicians	I, 15 D to 1 Y and/or fine		

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
	1930			Life								I, 2 to 10 Y	I, 2 to 5 Y		
ica															
	1966-1976			-Life -Health						Abortion has to be carried out by a physician or a surgeon, after consultation with another physician and after notification of the State Director of Health and Administrative authorities		-I, 1 to 5 Y and fine -Harsher penalities for medical personnel	I, 6 M to 2 Y		

Table A.XIX.3 (Continued)

Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
	On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
1937			-Health -Life	Danger of deformed or congenitally abnormal child.				Husband's consent required for abortion performed to save the life or preserve the health of the mother.	Certification of a team of medical doctors required.		-I -Harsher penalties for physicians and pharmacists	I		
1953-1973 + 1975			Life					Consent of the pregnant woman, or if she is minor, that of her guardian required.	Agreement of two gynecologists, one of whom is performing the operation required.		I, at least 6 M	I, at least 6 M		

Table A.XIX.3 (Continued)

Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
	On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
1962-1967			Health					- Spousal consent required - Where pregnancy is interrupted without spousal consent, the chief medical officer must be informed	Abortion has to be openly performed by a physician.		-I, 1 to 5 Y and fine -If habitually double penalty.	I, 6 M to 2 Y and fine.		
1925			Life								I, up to 5 Y and/or fine			

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
	1973	On request		-Health -Mental balance	Danger of serious infirmity			Within 3 months (on request)	Consent of the woman required	To be performed by a physician	In hospitals or authorized clinics	Punishable if performed in violation of the law.			
frica															
	1964			-Life -Physical health -Mental health									I, up to 3 Y	I, for several Y (medication or instrument)	
				Life											
ica	1975			-Life -Physical health -Mental health	Danger of a physical or mental defect.	-Rape -Incest -Pregnancy resulting from intercourse with women who are idiots or imbeciles				Certification of the woman's physician and of two other physicians required.	-Government hospitals -Approved medical institutions	Punishable by imprisonment for up to 5 years and/or by fine, if performed in violation of the law.			

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	Remarks
				-Life -Physical health -Mental health							-Government hospitals - In practice, it is reported that those who can not afford to pay are treated free of charge.				The present status of abortion legislation is not known; the basis of law is still the statutory law of South Africa in force before 1965.
ica															
	1958 1973			Life			Abortion resulting from employment of any therapy is excused by legal system.			Agreement of a committee of three doctors (including the performer) and an expert attached to the civil courts required.					

Table A.XIX.3 (Continued)

Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
	On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
	No information													
1934			-Life -Health								I, for 14 Y	I, for 7 Y	I, for 3 Y	
1960 1962 1969			Medical or surgical treatment							Preferably government hospitals	I, up to 10 Y and/or fine.	I, up to 10 Y and/or fine		
1966			Health								-I, 1 to 2 Y and/or fine -For medical personnel, same penalties and suspension from the professional practice.	I, 16 D to 1 Y and/or fine		

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Bissau		No information													
oast	1958			Life						To be performed by physician with written certification of two other physicians						
	1979			-Physical health -Mental health	Danger of serious defects	-Rape -Other felonious intercourse.	If the girl at the time of intercourse was below the age of 16.			Certification of two physicians					Methods used to prevent implementation of a fertilized egg and a self-abortion by the pregnant woman do not constitute criminal offenses

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Mali	1961			Life								-I, 1 to 5 Y and fine -Harsher penalties for physicians and pharmacists	I, 1 to 5 Y and fine		
Mauritania	1972			Life								I, 1 to 5 Y and fine	Fine		
Niger	1961			Life								I, 1 to 5 Y and fine	I, 6 M to 2 Y and fine		
Nigeria	1958			-Life (in northern states) -Allowed in other states under the authority of court decisions.						In practice, approval of two medical practitioners required.		I, up to 14 Y	I, 7 to 14 Y	I, up to 3 Y (except in the northern states where the penalty is not specified.)	

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Senegal	1965			Life						Performing physician must receive written certification from two other doctors		I, 1 to 5 Y and fine	I, 6 M to 2 Y and fine.		
Sierra Leone	1939			-Life -Health								Penalties are imposed			
Togo	1810			-Life -Health											
Upper Volta	1810			Life											

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Eastern Europe		**Area of responsibility of the Economic Commission for Europe**													
Bulgaria	1973 1974	On request for woman with more than one living child and provided there are no specially listed medical contra-indications	-Where the pregnant woman is un-married. a widow, sepa-rated from her husband -Where she has one living child and is over 40 Y	-Where not allowed on request if there exist medical indi-cations officialy listed. -In cases of disease not listed. per-mission may be granted by special board.	Included in the list of diseases	Rape	Pregnant woman is an alien	On request within 10 weeks	Autho-rization by boards established at dis-trict hos-pitals for termination of preg-nancy on medical indications of woman without child or with one living child	Only in hospitals and by physicians specialized in obstetrics and gynecology	-for physician I. up to 3 Y -For others I. up to 5 Y	Not criminally responsible			

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Czechoslovakia	1973		Difficult conditions for the life of the woman or her children such as: -Woman is over 40 Y (social condition) -Woman has three or more living children -Unmarried woman -Woman has lost her husband or he is in a poor state of health -Poor standard of living (housing, financial situation) -Family unit broken down	Medical indications officially listed	Included in the list of medical indications	-Rape -Other criminal offense	-If intra-uterine contraception has failed -If conception occured before 15 or after 45 years (age as a medical indication)	-For medical reasons during the first 12 weeks -For eugenic reasons during the first 24 weeks.	Minors do not need parental consent	Approval of a three-member district committee required	-Hospitals (department of gynecology) -As an exception to free health care, a fee is charged (except in exceptional cases)	I, 1 to 5 Y		Not criminally responsible	

Table A.XIX.5 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
German D.R.	1972	On request	Covered by the indication "for other important reasons" in the law	-Physical health - Mental health	-Covered by the indication "for other important reasons" in the law	-Rape -Certain other forms of sexual misconduct		-On request: during the first trimester		-Permission of a commission of medical expert needed for abortion to be performed after the first 12 weeks -Abortion is normally not allowed if there has been an abortion in the previous 6 months.	-To be performed by a physician in a recognized clinic. -Abortion itself, its preparation and post operative treatment considered illness for the purpose of employment and social insurance	Abortion after the first 12 weeks is generally illegal under the criminal code.			

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Hungary	1973	Subject to authorization by special committees; but women who are single, divorced separated from their husbands (at least 6 M), widows, over 40 Y or who have at least 3 children possess right to have authorization	Where woman or spouse -Have no available accommodation -Serving prison sentence (at least six M) -Other social grounds of an imperative nature.	Medical indication	-Probable medical indication affecting the conceptus -Abortion may be granted if woman has 2 living children and anticipate that the viability of the conceptus or its health development are threatened	Criminal act	-If intrauterine contraception has failed - If the woman has 2 children and has undergone, in addition, at least one "obstetrical event"	-For medical reasons: No limit -For other reasons: Up to 12th week of pregnancy and 8th week for for a minor (if procedural delays up to 16th week)	-Consent of the woman and "hearing" of the husband before the committee -For a minor, consent of the legal representative can be substituted by a decision of the committee	Authorization by special committees required in all cases	-In patient health care establishment -Fee regulated by law				

Table A.XIX.5 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Poland	1956 1969		Where the pregnant woman is (or would be after the child were born) in difficult living conditions"	Health	Not expressly permitted but usually considered as a reason of "difficult living conditions"	-Rape -Other criminal acts			Consent of parents or guardians required for minor	-The physician has to decide if the reasons stated by the woman are sufficient -If he refuses, patient can request decision of a medical board	-Hospitals and clinics -Offices of private physicians	Punishable	Woman not criminally responsible for terminating her own pregnancy or cooperating in such a termination		

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Romania	1957 1966			-Life -Physical -Mental	-Where one of the parents suffers from a serious disease of a heredity nature or -One liable to cause serious congenital malformation	-Rape -Incest	-Woman is more than 45 Y -She has four children under her care	-First three months - For life's reasons up to the sixth month		Approval of a medical board required	Specialized health unit	Punishable	Punishable		

Table A.XIX.5. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Northern Europe															
Denmark	1973	On request	Where pregnancy, childbirth or care of child constitutes a serious burden; following will be taken in account - Interests of the woman - Management of the household - Care of the other children - Age of woman - Effort involved in her occupation - Her personal circumstances or(those of her family) including housing, income, health	-Life -Physical health -Mental health	Danger of serious physical or mental disorder	- Rape - Other criminal acts	Where, on account of her youth or immaturity(if woman is incapable of giving proper care to the child)	On request first 12 weeks after that time, illegal except for medical reasons or with authorization of a special committee	For woman under 18 Y or legally incompetent, consent of parents or guardian required, but committee can decide that consent is not necessary	Committee approval required after the first 12 weeks of pregnancy	-State or communal hospitals - Attached clinics (ambulatorium) - Fees following law	- I, up to 2 Y or fine for physician - I, up to 4 Y for non-physician			

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Finland	1970 1978		-Disease or mental dis-function will affect the ability of either or both parents to take care of the child -Delivery of a child and its care in infancy would place a serious strain upon the mother in relation to her general living conditions and those of her family	-Life -Health	-Danger of serious disease or serious physical or mental defect	-Criminal offenses	-Where the woman was under 17 or over 40 at the time of conception -Where she already has given birth to at least four children	-For any reasons, up to the 12th week -For medical reasons, up to 20th week allowed		In most cases, recommendation of two physicians or authorization of the State Medical Board required	Approved hospitals or institutions, except in an emergency	Hard labour up to 4 y	I, but taking in account circumstances, the court may refrain from punishing the woman		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remark.
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Iceland	1975	Where pregnancy and child will cause the woman and her close relatives excessive problems on account of unsurmountable social circumstances the following will be considered: -Woman has given birth to several children at frequent intervals and only a short time has elapsed since the previous birth. -Woman lives in difficult family circumstances due to the presence of young children or to serious ill health of other persons in the household	- Life - Physical health - Mental health	-Danger of malformation or child will suffer from serious disease due to genetic factors or damage which occured during the fetal phase	-Rape -Other criminal acts				-For woman under 16 Y or legally incompetent joint request by the woman and her parents or legal representative - For mentally handicapped woman request by the legal representative -For married woman, joint request by woman and her husband, unless inadvisable	-Written report of two physicians required -In case of non-agreement matter shall be submitted for a decision to a 3 member-committee	Approved hospitals	I, 5 to 7 Y			

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities		Place of termi-nation and insurance/ social security coverage	Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval		Performer	Woman	Supplier	
			- Woman could not look after a child satisfactorily in view of her youth and lack of maturity												
			- Other circumstances												
			- Where physical or mental disease seriously reduces the capacity of the woman or her partner to care for or bring up a child												
Ireland	1861						Life					1, 2 Y to life		1, 2 Y to life	

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Norway	1978	On request	-Where pregnancy, childbirth or care of the child may place the woman in difficult circumstances -Abortion on the ground of health, eugenic and socio-economic reasons will take in account the overall situation of the woman, including the extent to which she can provide the child with satisfactory care	-Life -Physical health -Mental health	-Major risk for the child of serious disease as a result of his or her genotype, of a disease or of harmful influence during pregnancy -Where woman is suffering from severe mental illness or is mentally retarded to a considerable degree	Criminal act		-On request, up to the end of the 12th week -Other grounds from the end of the 12th week up to the 18th week -For particularly important grounds after the 18th week	-Consent of the woman required -For woman under 16 Y. opinion of her parents or guardian considered	-For abortion after the 12th week, authorization of a committee of 2 physicians required	-Up to the 12th week, approved institutions -After the 12th week, hospitals only				

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Sweden	1974	On request (for Swedish citizen or resident with special authorization of the National Board of Health and Welfare	May be considered as "substantial grounds"	-Life -Health -Special grounds	May be considered as "substantial grounds"	May be considered as "substantial grounds"		Any reasons may justify an authorization of pregnancy termination after the 18th week, insofar as they can be determined to be "substantial grounds"	- On request up to the end of the 18th week -Other reasons, after the 18th week	After the 18th week authorization of the National Board of Health and Welfare required	-General hospital or approved establishment, except in emergency -Procedures free until the 18th week	I, up to 1 Y or fine for non-physicians			

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
United Kingdom	1967		Actual or reasonably foreseeable environment of the woman may be taken in account in determining the risk involved for medical and eugenic reasons	-Life -Physical health -Mental health -Physical and mental health of children	Danger of serious physical or mental abnormalities					Approval of two registered physicians, except in emergency	-Hospital covered under the National Health Service Act or approved establishment -Free under National Health Service				
Southern Europe															
Albania	1977			-Life -Health									I, up to 8 Y		

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-Economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Greece	1950 1978			-Life -Physical health -Mental health	Danger of birth of children with defects	-Rape -Incest	Seduction of a girl under 16 Y	-For mental health reasons up to the 12th week -For eugenic reasons, up to the 20th week		For life and physical reasons, doctor other than the performing physician must certify the need and for mental health, a psychiatrist working in a public health establishment		I, at least 6 M	I, up to 3 Y	I, at least 6 M	
Holy See	No information														

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Italy	1977 1978	On request - After advice at a consulting center or a health or welfare agency - Waiting period of 7 days before the operation	Economic and social circumstances listed as situation which can endanger the woman's health	-Life -Physical health -Mental health	Danger of serious abnormalities or deformations			-On request during the first 90 days +For health or eugenic reasons after the first trimester	-Minor women (under 18) need parental consent or consent of the guardian -Decision of a magistrate can replace those of the parents, if not advisable to consult them or if they refuse	After the first 90 days for health or eugenic reasons, certification of a specialist in obstetrics and gynecology of the hospital where the pregnancy will be interrupted, needed -During the first 90 days after a seven day waiting period and after advice at a consulting center or health and welfare agency.	-General or specialized public hospitals - Authorized private establishment during the first 90 days			Criminal provisions included in the 1977 law.	

Table XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	Remarks
Malta	1942			Life								- I, 18 M to 3 Y - Harsher penal-ties for physicians and phar-macists	I, 18 M to 3 Y		
Portugal	1886 1956			Life								I, 2 to 8 Y	-I, 2 to 8 Y -Less severe if woman committed the offense in order to conceal her dishonor		
San Marino	No information														

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	Remarks
Spain	1963			Life								-I, 6 M to 6 Y -Harsher penalties for physicians and midwives	I, 6 M to 6 Y		
Yugoslavia	1974 (Federal) 1977 (Slovania) 1978 (Croatia)	-On request up to the 10th week -In Slovania and after the 10th week. If there is a risk to the woman's life, health, or future motherhood that is less than the risk to the woman or the		- Life - Health (Croatia)	Danger of serious congenital, physical or mental defect (Croatia)			-On request up to the 10th week -Other reasons after the 10th week. (following states)	-In Croatia, women under 16 Y need parental consent -In Slovania, application for legally incompetent woman has to be filled by parents or guardian For minor, the health care insti-tution	-After the 10th week, autho-rization of a First Level Commit-tee needed -Possi-bility to appeal to a Second Level Committee	-Hospital with department of gyne-cology or specially authorized establishments -Cost of abortion are normally paid by the health insurance system				

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	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Yugoslavia		child associated with continuation of the pregnancy							must normally inform parents unless the woman has been recognized as fully competent to earn her living.		-After the operation, woman is entitled to adequate care and sick leave				
Western Europe															
Austria	1974	On request		-Life -Physical health -Mental health	Danger of grave physical or mental defect			Where woman became pregnant when under 14 Y	-On request, during the first three months after nidation - Other reasons, after the first three months	Consent of the woman	To be performed by a physician after medical consultation	-I, up to 1 Y for a physician -I, up to 3 Y for non-physician	I, up to 1 Y		In practice, restricted in hospitals and expensive in private establishment

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Belgium	1867			Life						Practitioner must consult 2 other established doctors and give notice to the Council of the Order of Physicians	- For physicians and pharmacists I, 10 to 15 Y	- I, 2 to 5 Y and fine	I, 2 to 5 Y and fine		Repressive legislation not enforced
France	1979	On request "Woman in distress situation"		-Life -Health	Danger of serious disease or condition considered to be incurable			-On request up to the 10th week -Other reasons, after the 10th week	Parents' or guardian's approval for minor	On request: -Woman must consult a counselling institution and - waits for a period of one week from her initial request	-Public hospital or authorized private hospital - Private hospital may refuse to perform - For therapeutic abortion, covered by Insurance Plan - For other cases, it is not free but help if needed				

Table XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Germany, F.R. of	1974 1975 1976		Present and future living conditions of the woman taken into account, according to medical findings as part of the evaluation of the health risks	-Life -Physical health -Mental health	Presuming the child's health will be irremediably injured	Certain crimes		-Eugenic reasons up to the 22nd week after conception -Juridical reasons up to the 12th week after conception		-Woman has to consult councellor 3 days before interruption -Performing physician needs written confirmation from another physician for health, juridical and socio-economic reasons of abortion.	-Hospitals or authorized establishments Health insurance laws were reviewed so as to afford medical treatment, supplies of medicines, drugs and dressing material, as well as hospital care to persons undergoing a "not unlawful" termination of pregnancy	I, up to 1 Y and in particularly serious cases, up to 5 Y or fine	I, up to 1 Y or -fine but the court may refrain from punishing her	Procedures that take effect before nidation of the fertilized ovum in the uterus are not deemed to be abortion within the meaning of the law	
Liechtenstein		No information													

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Luxembourg	1978		Where the living conditions which may result from the birth are likely to endanger the physical or mental health of the woman	-Life -Physical health -Mental health	-Danger of serious disease, serious malformation or considerable mental defects	Rape		Up to the 12th week		-Woman has to consult a gynecologist who has informed her of the medical risks involved in abortion - Indications for abortion must be certified by another physician than that who performs	Hospital or approved establishment	I, 2 to 5 Y and fine	-Fine -No offense if she acts under the pressure of situation of distress		
Monaco	1967		Life									-I, 1 to 5 Y and fine -Harsher penalties for medical personnel	I, 6 M to 3 Y and fine		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Netherlands	1881			-Life -Health								- I, up to 4 1/2 Y - Harshe penalties for physicians, pharmacists or midwives	-I, up to 3 Y	-Repressive legislation not enforced -Practice very liberal and several non profit clinics, specializing in pregnancy interruptions operate in the country	
Switzerland	-Federal law 1937 -Implementing regulations were issued by the Cantons: Geneva 1954 Vaud 1968			-Life -Health	In practice rape				Written consent of the woman	The performing licensed physician has to receive a second opinion from another licensed physician		Penal servitude up to 5 Y	-I, for 3 Y or more		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Western South Asia (part)								**Area of responsibility of the Economic Commission for Europe (Cont'd)**							
Cyprus	1959		Socio-economic grounds	-Life -Physical health -Mental health	Danger of deformed or retarded child	-Rape -Such circumstances that, if the pregnancy were not terminated, the social status of the woman or her family should be seriously jeopardized				For juridical reasons, consent of police authority and medical practitioner -For medical and eugenic reasons, approval of a second registered medical practitioner		I, for 14 Y	I, for 7 Y	I, for 3 Y	

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	Remarks
Israel				-Life -Physical health -Mental health	Danger of physical or mental defect	Pregnancy resulting from: - Sexual relations prohibited by criminal code - Incestuous relations - Extra marital sexual relations	Where the woman is under the minimum age of marriage or over 40		Consent of minor does not require approval of her representative	Approval of a 3 member committee (2 physicians and a social worker) required after interview with the woman	Recognized medical institutions				

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Turkey	1965			Life	-Abnormalities in fetal development or of a genetic nature -Risk of a child having a hereditary defect	-Rape -Other crimes			-Consent of the woman required -Or her guardian in the case of a minor -Or a Court in the case of delinquents and persons who have lost their legal rights.	The Therapeutic Abortion Committee must approve all pregnancy terminations, unless emergency	Establishments determined by the Ministry of Health and Social Welfare	1, 2 to 5 Y	-If she performs herself 1, 1 to 4 Y -If she consents only 1, 1 to 5 Y		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Northern America															
Canada	1955 1970			- Life - Physical health - Mental health						Qualified medical practitioner may perform an abortion with written certification of a Therapeutic Abortion Committee of the hospital (3 physicians)	-Accredited or approved hospital -Provincial Government Hospital and medical plans, where applicable	Life I	I, for 2 Y	I, ? Y	
United States															
	Supreme Court 1973 statute may vary in the individual states	On request		- Life - Health				On request: first trimester and second trimester -After viability of the fetus or in "the third trimester" only if it							Abortion performed by a non-physician remains an offense

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Table A.XIX.3. (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	
United States								is necessary to save the life or to protect health from serious injury		-Prior to the end of the first trimester decision of the woman and her physician -In the second trimester the state, in promot-ing its interests in the health of the woman, may regulate the abor-tion pro-cedures in ways that are reasonably related to maternal	-For the first tri-mester, no regu-lations -For the second trimester, usually in medical establishments of a certain kind -For the third trimester, Public hos-pitals cannot refuse to perform abortion; Private hos-pitals may prohibit abortion or refuse to perform them				

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Table A.XIX.3. (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	
United States										health. - For the "Third tri-mester", i.e. the stage subsequent to viability, the state in promoting the poten-tiality of the human life may regulate and even prescribe, abortion, except where it is necessary in appro-priate medical judgement, for the preservation of the life and health of the woman. Viability is usually placed at about 7 months (28 weeks) but may occur earlier, even at 26 weeks.	-Congress as well as many states limited payment for abortion from federal or state funds, except for abortion for medical reasons				

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Union of Soviet Socialist Republics															
Byelorussian SSR				No information											
Ukrainian SSR				No information											
USSR	1965 1960 1969	On request		Permitted for medical reasons	Permitted on genetic grounds, for hereditary diseases, etc...			-During the first 12 weeks -Later for medical reasons	-		-Only hospitals and approved establishments - Therapeutic abortions are free; for other legal abortion, small fee is charged - Free also for working women	Deprivation of freedom up to 1 Y or correctional tasks if performed by a physician -Deprivation of freedom up to 2 Y or correctional tasks if performed by non-physician	Woman is not criminally responsible	Abortion is permitted on request, but dissuasion campaign for natalist reasons	

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Area of responsibility of the Economic Commission for Latin America															
Caribbean															
Bahamas			Where it may be interpreted as a risk to health.	-Life -Physical health -Mental health	Where it may be interpreted as a risk to health			-In practice within 20 weeks -Majority under 12 weeks		Registered medical practitioner	Hospital, not necessarily government				
Barbados	1868 1944			-Life -Physical health -Mental health								1	I	I, 2 to 5 Y	
Cuba	1979	On request						First trimester			Free				
Dominica				Life											

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Dominican Rep.	1948			Life								-I, 2 to 5 Y -For medical personnel 5 to 20 Y of hard labor	I, 2 to 5 Y		
Grenada	1935			-Life -Health								I, up to 10 Y	I, up to 10 Y		
Haiti	1835			Life								-I, 3 to 9 Y -Harsher penalties by physicians and pharmacists	I, 3 to 9 Y		

Table A.XIX.3. (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	Remarks
Jamaica	1864 1975			-Life -Physical health -Mental health								-Life I or -I, for not less than 3 Y or -I, for less than 2 Y but with or without hard labor.		-I, for more than 3 Y or -I, for less than 2 Y with or without hard labor	
St. Lucia				-Life -Physical health -Mental health											
St. Vincent and the Grenadines				-Life -Physical health -Mental health											

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Trinidad + Tobago	1925 1950			-Life -Physical health -Mental health									I, for 4 Y		
Middle America															
Costa Rica	1970			-Life -Health					Written consent of the woman and her husband required	-The Performing physician has to consult other physicians. -Authorized midwife can also perform an abortion.		-I, 1 to 3 Y -If fetus is less than 6 M, I, 6 M to 2 Y	-I, 1 to 3 Y -If fetus is less than 6 M, I, 6 M to 2 Y		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
El Salvador	1877			Life	Grave deformity of the fetus	Rape			Consent of the mother required	Consultation with another physician required (in the case of saving life)		I, 2 to 4 Y	I, 1 to 3 Y		
Guatemala	1973			Life						Performing doctor must consult with another doctor		-I, 1 to 3 Y -Harsher penalties for medical personnel	I, 1 to 3 Y		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Honduras	1906 1964			-Life -Health (after other methods have been tried without success)					Written consent of the mother and her husband or the closest relative required.	Authorization by medical commission required.		I, 2 to 3 Y	Less severe penalty		
Mexico	1931			Life		Rape			Consent of woman required	Performing doctor must consult with another doctor (except in emergency cases)		I, 1 to 3 Y	-I, 6 M to 5 Y -I, 6 M to 3 Y where the interruption of a concealed pregnancy, resulting from an illegitimate relationship was performed by a woman of good reputation.		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Nicaragua	1949			Life								I, 1 to 2 Y	I, for 4 Y or for 2 Y		
Panama	1922			Life								-I, 20 M to 3 Y -Harsher penalties for medical personnel and for the husband.	I, 8 M to 30 M		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Temperate South America															
Argentina	1921 1967			-Life -Health		-Rape (if criminal procedure initiated) -Incest					Only licensed physicians can perform	- I, 1 to 4 Y - I to 6 Y, if the woman dies following the operation.	I, 1 to 4 Y		
Chile	1967 1976			Life							Beside the performing physician written approval of two physicians required.	- I, 540 D to 3 Y - Harsher penalties for physicians	I, 3 to 5 Y		

Table XIX.5. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remark
Uruguay	1933		Serious economic difficulty (punishment reduced by from one-third to one half or may be waived)	Life		Rape (punishment may be waived)		Within the first three months		To be performed by a physician.		I, 6 M to 24 M	I, 3 M to 9 M		
Tropical South America															
Bolivia	1972			-Life -Health		Pregnancy resulting from certain sexual crime				The performing physician needs judicial approval		-I, 1 to 3 Y -if performed habitually I, 1 to 6 Y -Interruption of pregnancy committed through negligence is an offense.	-I, 1 to 3 Y -Unsuccessful attempt not punishable		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Brazil	1940 1941			-Life		Rape				For therapeutic abortion, the attending physician needs authorization of a committee of three physicians called into conference		1, for at least 4 Y	1, for at least 4 Y		
Colombia	1936			Life		Reduction in sentence of from one half to two-thirds, or even judicial pardon, may be prescribed for an abortion performed to protect the honour of one's mother, spouse, daughter, sister or adopted daughter.						-1, 1 to 4 Y -Harsher penalties for medical personnel	1, 1 to 4 Y		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Ecuador	1938			Life		-Rape -Cohabitation with a retarded or insane woman			For abortion on juridical ground, consent of legal representative of the woman required			-I, 2 to 5 Y -Harsher penalties for medical personnel	I, 6 M to 5 Y		
Guyana	1954			-Life -Health (presumably)								-Life I	I, for 10 Y	I, for 5 Y	
Paraguay	1909			Life								-I -Harsher penalties for medical personnel and husband	I		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Peru	1924 1969			-Life -Health						Approval of two physicians required		-I, up to 4 Y -Harsher penalties for medical personnel	I, up to 4 Y		Since human life begins with conception, abortion based on any ground (moral, social, economic or as a means of birth control) except for saving life or health of the mother, is prohibited
Surinam		No information													

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Venezuela	1964			Life					Consent of the woman and relatives to be obtained by the physician after adequate explanation on necessity of the abortion and on procedures.		-Suitable environment -Using all possible scientific resources	- I, 12 M to 30 M - Harsher penalties for medical practitioner and husband	I, 6 M to 2 Y		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Western South Asia								**Area of responsibility of the Economic Commission for Western Asia**							
Bahrain	1956			Life								I, for 10 Y	I, up to 5 Y	I, for 3 Y and/or fine	
Dem. Yemen	1969			Life								I, for 3 Y and or fine	I, for 3 Y and/or fine		The 1969 law is applied for ADEN's region. Elsewhere, the Islamic religious law and tribal law are in force
Iraq	1969			Life						Recommendation by two medical specialists required		-I, for 1 Y and/or fine -Harsher penalties for physicians.	I, for 1 Y and/or fine		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Jordan	1960 1971			-Life -Health					Written consent of the woman or if legally incompetent, her husband or legal guardian	Certification of two licensed doctors	Licensed hospital or nursing home	-I, 1 to 3 Y -Harsher penalties for medical personnel	I, 6 M to 3 Y		
Kuwait	1960			Life						To be performed by an obstetrician		-I, up to 10 Y and/or fine - Harsher penalties for medical personnel	I, up to 5 Y and fine	I, up to 3 Y and/or fine	

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Lebanon	1943 1969			Life					Consent of woman required except in case of emergency or incapacity	Certification by two physicians other than the performer required		I, 6 M to 3 Y	I, 6 M to 3 Y		
Oman	Since 1966 Islamic religious law is in force														
Qatar	1971 Criminal Code but no information														
Saudi Arabia	Islamic religious law is in force			Life											

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Syrian A. Rep.	1949 1970			Life					Written record concerning the abortion signed by the woman and her husband (or a guardian) is required	Performer has to be a medical specialist and reach agreement with another medical specialist		-I, 1 to 3 Y -Harsher penalties for doctors and pharmacists	I, 6 M to 3 Y		
United Arab Emirates				No information											
Yemen	Seemingly Islamic religious law is in force but criminal law in 1963.														

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	Remarks
Area of responsibility of the Economic and Social Commission for Asia and the Pacific															
China															
China	1979	On request (incentives and disincen-tives)						Usually 3 months			-In hospitals, clinics, and dispensaries -Abortion services are free -After pregnancy termination a woman receives 14 days sick leave with pay, or 30 days if the preg-nancy has been terminated after three months.				-The criminal code of China is at the present time the only code entirely de-criminalizing abortion - In addition to all contra-ceptive methods, widely practised as a method of family plann-ing.

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Japan															
Japan	1907 1948		When from an economic viewpoint, continuation of pregnancy or delivery may seriously affect the health.	Health (continuation of pregnancy or delivery)	Husband or relative within the fourth degree suffers from heredity diseases or defects	-Rape -Fornication without the legal consent of the woman		24 weeks	Authorization of husband required		Not free but cheap	-I, up to 2 Y -Harsher penalties for doctors and pharmacists	I, up to 1 Y		
Other East Asia															
D.P.R of Korea	1950		Interruption of pregnancy allowed "for important reasons".								Presumably free of charge	I, up to 3 Y	Woman inducing her own abortion or allowing another person to do so is not criminally responsible.		

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Mongolia	1960			-Life -Health								-If performed by physician I, up to 2 Y -If performed by a person who does not have the higher medical qualification or if performed under unsanitary conditions I, up to 5 Y	Presumably, woman inducing her own abortion or allowing another person to do so is not criminally responsible		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
R. of Korea	1973			-Life -Health -Mother suffering from certain infectious diseases	-If the woman or her spouse suffers from hereditary mental or physical disease -Suspected or confirmed foetal abnormality	-Rape -Incest -Other unlawful intercourse		Before the end of 28th week	-Consent of the woman and husband required -If not possible to obtain the spouse's consent that of the woman alone is sufficient.			-I, up to 1 Y or fine -Harsher penalties for medical personnel	I, up to 1 Y or fine		

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insaurance/ social security coverage	Performer	Woman	Supplier	
Eastern S. Asia															
Burma				Life								I, up to 3 Y and/or fine	I, up to 3 Y and/or fine		
Dem. Kampuchea				No information											
Indonesia	1915			Life								- I, for 5 1/2 Y - Harsher penalties for medical personnel	I, up to 4 Y		
Lao P.D.R.	1922 1965			Life									I, 5 to 10 Y		

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Malaysia	1976			Life	Permitted	Permitted			Consent of the woman required		Free if performed in Government hospitals	- Where the woman is in the early stage of pregnancy I, up to 3 Y and/or fine - Where the fetus can be felt or in the late period of pregnancy I, up to 7 Y and/or fine. - If done without the consent of the woman I, up to 20 Y and fine.			
Philippines	1930			Life								I, 6 M to 6 Y -Maximum penalty specified above for physicians and midwives.	I, 6 M to 6 Y		

Table XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Singapore	1974	On request (if the woman is a citizen or resident of Singapore)		-Life -Physical health -Mental health				Up to the 24th week (except for life and health)	Written consent of the woman required		-Government hospitals or approved institutions -Cost of abortions carried out in a government hospital is low ($5)	I, up to 3 Y and/or fine			
S.R. of Viet Nam	No information														
Thailand	1956			-Life -Health	-Rape -Certain other crimes							I, up to 5 Y or fine	I, up to 3 Y or fine		

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Middle South Asia															
Afghanistan	1976			Life								I, 24 M to 15 Y depending on the circumstances of the case or a fine			
Bangladesh	1860			Life						Opinion of two approved medical practitioners required in practice.	Operations at Government hospitals or health centers are free, in practice.	-I, up to 7 Y with or without fine -If carried out without the consent of the woman or if she dies I, up to 10 Y and fine -Jail for life is an alternative punishment.	-I, up to 7 Y with or without fine -Jail for life is an alternative punishment		

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Bhutan		No information													
India	1971-2 1975		Actual or foreseeable socio-economic environment may be taken in account when health of mother is considered	-Life -Physical health -Mental health	Danger of serious physical or mental abnormalities	-Rape	-Failure of contraception on the part of the wife or husband		- Consent of woman required - For minor or mentally ill woman, written consent of the guardian required.	-Length of the pregnancy less than 12 weeks, medical practitioner can perform -Length of the pregnancy between 12 and 20 weeks approval of two medical practitioners required, urless emergency.	-Hospitals established or maintained by the government -Place approved by specific legislation (except in emergencies)	-1, for 3 Y and and/or fine	1, for 3 Y and/or fine - If fetus seemingly alive 1, up to 7 Y		

Table A.XIX.3 (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Iran a/	1974 1976		Social or medico-social reasons	-Life -Physical health -Mental health	Incurable defect	-12 weeks for social and medico-social grounds -First trimester for other reasons			-Written consent of the "parents required" (of the woman alone if she is unmarried) -Abortion on the ground of mental illness of one of the parents, written consent of a guardian required -Abortion on the ground of health, consent of the mother alone required	For medical reasons, performing physician needs "endorsed opinion" of two other physicians -For social or medico-social reasons, a physician can perform	Hospitals and clinics				No information concerning the law in the new government.

Table A.XIX.3 (Continued)

	Date of law or of the last amend-ment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termi-nation and insurance/ social security coverage	Performer	Woman	Supplier	
Maldives		No information													
Pakistan				Life								- I, up to 3 Y and/or fine - If fetus seemingly alive, I, up to 7 Y and fine	-I, up to 3 Y and/or fine -If fetus seemingly alive, I, up to 7 Y and fine		

Table XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			
		On Request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	Remarks
Nepal	1976			On grounds of "benevolence".							- Without the consent of the woman I, for 2 Y, if pregnancy is less than 6 M I, for 3 Y, if pregnancy is more than 6 M - With the consent of the woman I, for 1 Y, if pregnancy is less than 6 M. I, for 1 1/2 Y if pregnancy is more than 6 M. - Abortion resulting from violence I, for 3 M if pregnancy is less than 6 M. I, for 6 M, if pregnancy is more than 6 M. - Abortion resulting from violence without knowledge that the woman is pregnant, fine (amount depending of the length of pregnancy)				

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Sri Lanka	1883 1956			Life					Consent of woman required			-I, up to 3 Y and/or fine -If fetus seemingly alive, for up to 7 Y	I, up to 3 Y and/or fine		
Australia/New Zealand															
Australia	Criminal statutes differ from one state to another	On request but on grounds of health (northern territory)	Actual or foreseeable socio-economic environment may be taken in account in determining risk to the life or health of the woman (South Australia)	-Life -Physical health -Mental health	Substantial risk of severe defect (northern territory and south Australia		In practice (South Australia)					I, 10 to 15 Y	Special sentence terms.		

Table XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
New Zealand	1961 1977-78			-Life -Physical health -Mental health	Danger of physical or mental abnormality	-Incest -Rape in itself is not a ground for abortion, but it may be taken into account under the medical indication	-Woman severely subnormal -Woman's being near the beginning or the end of the usual child bearing years, while not being a ground "in itself" can be taken into account under the medical indication	-For serious danger to the physical or mental health of the woman, not more than 20 weeks -After 20 weeks, only to save the life or to prevent serious permanent injury to physical or mental health.	Approval of two physicians who are official "certifying consultants"	-Licensed institutions -If pregnancy exceeds 12 weeks, only institutions with "full license"	I, up to 14 Y	Fine			

Table A.XIX.3. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/ social security coverage	Performer	Woman	Supplier	
Melanesia															
Papua New Guinea	1899 1902			-Life -Physical health -Mental health								Penalties	Penalties		
Solomon Island				Life											
Micronesia-Polynesia															
Fiji	1976			-Life -Physical health -Mental health	Eugenic, juridical or socio-economic reasons are not a ground in and of themselves but may be taken into account when judging the repercussions of pregnancy on the life and health of the mother							I, for 14 Y	I, up to 7 Y	I, for 14 Y	

Table XIX.5. (Continued)

	Date of law or of the last amendment to the law	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for [b]			
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	Remarks
Kiribati				Life											
Nauru	1899			Life											
Samoa	1969			-Life -Physical health -Mental health											
Tonga				Life											
Tuvalu	No information														

a/ The law legalizing voluntary abortion on both medical and social grounds have now been repealed

b/ Key: I= Imprisonment
M= Month
Y= Year

Source:
1. Compiled from United Nations Fourth Population Inquiry Among Governments in 1979 and Population Division, Population Policy Data Bank.
2. United Nations Fund for Population Activities 1979, Survey of Laws on Fertility Control.
3. World Health Organization, Geneva, 1979, International Digest of Health Legislation, Vol.30, NO.3

Table A.XIX.4. Legal status and grounds for granting a sterilization by areas of responsibility of regional commissions and geographical regions, July 1980

	Legality		Grounds	Age	Type of sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Eastern Africa		1940	**Area of responsibility of the Economic Commissionrfor Africa**					
Burundi		No specific provision, but seemingly assimilated to law dealing with intentional infliction of a corporal injury.						
Comoros	No information							
Djibouti	No information							
Ethiopia	1957 No specific provision, but seemingly legal if requested by patient and neither forbidden by law nor offends public decency.		On request but at least five living children and difficult socio-economic condition of the mother (as well as health reasons)	Preferably persons over 35 years.	In practice limited to women	Spousal consent requested	Hospitals	Practiced on a small scale with the support of the Family Guidance Association.
Kenya	1962 No specific provision, but the law dealing with an intentional infliction of a corporal injury is not applicable to sterilization.						State hospitals and clinics.	-Some sterilizations were performed -Since 1978 officially stated as a family planning method for the moment.

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Madagascar		1962 **No specific provision, but law dealing with intentional infliction of a corporal injury seems to be applicable to all forms of sterilization**						
Malawi		1929 No specific provision, but law dealing with intentional infliction of a corporal injury is in force except if done in good faith.						
Mauritius		1935 No specific provision, but law dealing with intentional infliction of a corporal injury, is not clearly defined as applicable or not to voluntary sterilization performed for family planning purposes.						
Mozambique		1956 **Non-therapeutic** sterilization is prohibited(no clarification about the legal situation after independence)						
Rwanda		1940 **No specific provision, but assimilated to law dealing with intentional infliction of a corporal injury.**						
Seychelles		No information						

Table A.XIX.4 (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
		1962						
Somalia		Illegal and punishable for both the surgeon performing the sterilization and the patient consenting to to such act.						
	1964							
Uganda	No specific provision, but law dealing with intentional infliction of a corporal injury may not be applicable to sterilization operation since it is done in good faith.		- After multiple caesarian operations. - After a woman had nine or ten children. - By mutual consent of the couple	In practice, performed on women who are over 40 years of age, on the advice of the Family Planning Association	In practice, only tubal ligations		In hospitals only	
	1950							
U.R. of Tanzania	No specific provision, but law dealing with intentional infliction of a corporal injury is in force except if done in good faith. Unclear if applicable to sterilization for medical reasons only or to sterilization for exclusively contraceptive purpose.							
Zimbabwe	No information							

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Zambia	1931 No specific provision, but law dealing with intentional infliction of a corporal injury is in force except if done in good faith.							
Middle Africa.	1956							
Angola	Contraceptive sterilization is prohibited.							
Central African Republic	1961 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and probably applicable to voluntary sterilization.							
Chad	1967 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and applicable to voluntary sterilization.							
Congo	1958 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and applicable to voluntary sterilization.							
Equatorial Guinea	No information							

Table A.XIX.4 (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Gabon		1963 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and there is no information as to the possible interpretation of this law.						
Sao Tome and Principe	No information							
United Rep. of Cameroon		1965 No specific provision, but law dealing with intentional infliction of a corporal injury is in force but may be not applicable to sterilization of a patient on his or her request						
Zaire		1930 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and there is no information as to the possible interpretation of this law						

Table A.XIX.4 (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Northern Africa								
Algeria		1966 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and probably applicable to voluntary contraceptive sterilization	-Therapeutic -Eugenic			Both spouses	Governmental medical institutions	
Egypt	1937 Law does not contain any text prohibiting sterilization operations undertaken with the consent of the patient but Islamic law permits it for health and eugenic reasons only		-On request, if the woman is over 35 yrs. old. -Has three or more children, at least one of them a boy. -Possible exception to these prerequisites -Eugenic	Woman has to be over 35 years old.	Tubal ligations (No information on vasectomies		-University hospitals -State hospitals (Dept. of Obstetrics and gynecology) -Private hospitals and clinics.	At official level, there is a project being implemented in three university hospitals to investigate comparative methods for surgical sterilization of women.
Libyan Arab Jamahiriya	No information							
Morocco		1962 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and there is no information as to the possible interpretation of this law.						There is a govt. program in family planning and some evidence that - Sterilizations are being performed in public hospitals in the cities

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/Incentives	Remarks
	Legal	Illegal						
Sudan		1925 No specific provision, but law dealing with intentional infliction of a corporal injury is in force and applicable to voluntary sterilization.						
Tunisia	1913 - 1973 No specific provision, but law dealing with intentional infliction of a corporal injury may not now be interpreted as applicable to voluntary sterilization.		On request, but must have four children	Very young women are excluded by the requirement of at least four children	Tubal ligations (vasectomies are considered to be less acceptable for cultural reasons)	Spousal consent required in practice	Performed by physicians in government hospitals and clinics.	Medical sterilization proclaimed an acceptable method of family planning.
Southern Africa								
Botswana	1964 No specific provision, but law dealing with an intentional infliction of a corporal injury is to be construed in accordance with English Criminal Code. Thus, the lawfulness of a contraceptive sterilization performed on the request on an informed patient may be supposed		On request, even for family planning purposes	-	Mostly female sterilization	Spousal consent required in practice	Hospitals	

Table A.XIX.4 (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Lesotho	No specific statutory provision on voluntary sterilization but legally, sterilization is considered to be a surgical operation like any other		Usually many children or medical grounds	Most sterilized women are in the 35-45 age group	Female sterilization only	-	Performed by a registered medical practitioner in a recognized hospital	Female sterilization freely practiced
South Africa	1975 The Abortion and Sterilization Act regulates only some issues of sterilization (persons incapable of consenting ...) but implies clearly that a competent person can consent to his or her own sterilization and that such consent makes the operation lawful.		On request (persons competent to give consent)	- Minors cannot be sterilized - Incompetent persons can be sterilized if existence of certain genetic dangers of mental incapability of parenthood, certified by two physicians and authorized by the legal representative and the the minister.				
Swaziland		No specific provisions and no information concerning the lawfulness of voluntary sterilization since the country became independent						

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Western Africa	1958							
Benin	When the country became independent, the French law was in force and purely contraceptive sterilization was considered a crime of intentional infliction of corporal injury. The present legal situation is not clarified.							
Cape Verde	No information							
Gambia	1966							
	No specific provisions but law dealing with an intentional infliction of a corporal injury is in force unless it is a reasonable surgical operation for the benefit of the patient. Whether the operations is to be considered reasonable depends on the state of the patient and on all the circumstances of the case.		Matter to be decided between patient and physician.					
Ghana	1960-1961							
	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force but provided that it is not a crime if done in good faith, for the purpose of medical or surgical treatment.		Mostly medical reasons			-Authorization of legal representative for incompetent persons -Spousal consent is not a requirement "in the delivery of family planning services".	Medical units throughout the country	

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Guinea	1965 No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and there is no information as to the interpretation of this law.							
Guinea-Bissau	No information							
Ivory Coast	1958 When the country became independent, the French law was in force and purely contraceptive sterilization was considered a crime of intentional infliction of corporal injury. The present legal situation is not clarified, but the government, as reported does not prohibit birth control.							There seems to be no interest in sterilization as a means of family planning.
Liberia	1956 No specific provisions; law dealing with an intentional infliction of a corporal injury is is force but no clear indication about the permissibility of purely contraceptive sterilization							

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Mali	1961	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force	Medical indications		Female sterilization only	Spousal consent required in practice	Hospital in capital city.	
Mauritania	1972	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force						
Niger	1961	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force						
Nigeria	1960	No specific provisions, but a surgeon can perform a voluntary sterilization operation upon any person for his benefit "... if performed in good faith, and with reasonable care ... and with the consent of the person".						

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Senegal	1965 No specific provisions; law dealing with an intentional infliction of a corporal injury is in force. But the question of possible applicability of this law to sterilization operations on consenting patients has not yet been clarified				Virtually no vasectomies			Voluntary sterilization for family planning purposes is rare, being employed only rarely by women with large families
Sierra Leone	1960 No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and its possible applicability to voluntary sterilization has not yet been clarified.							

Table XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Togo		No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and its applicability to voluntary sterilization presumably does not arise.						Not practiced in Togo
Upper Volta	1958 When the country became independent, the French law was in force and purely contraceptive sterilization was considered a crime of intentional infliction of a corporal injury. The present legal situation is not clarified.							

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Area of responsibility of the Economic Commission for Europe								
Eastern Europe								
Bulgaria	1968 No specific provision, but seemingly legal since law dealing with intentional infliction of a corporal injury is not applicable to voluntary sterilization considered as an act not socially dangerous.			Consenting mature person		No spousal consent required	Institutions of State Health Care	
Czechoslovakia	1966-1971-1972 Legal except if considered as "more than slightly socially dangerous"		-On request if the woman is over 35 yrs. old and had at least three children or the woman is younger than 35 but had four children - Medical - Genetic	35 years for women	Full equality guaranteed by broad possibility of vicarious male sterilization		State hospitals and clinics	Number of operations statistically insignificant.
German Dem. Rep.	1968 Legal for medical reasons; otherwise law dealing with intentional infliction of a corporal injury is in force but whether a sterilization performed in violation of the law might be punishable as such an offense might depend on the degree of "social danger" presented by the circumstances of the case.		- Medical		Regulations govern female sterilization only	No spousal consent required	-Obstetrics and gynecology departments of State Health Institutions -Physician has to consult with senior specialist in obstetrics and gynecology before advising a woman to be sterilized	Sterilization is not encouraged because of its irreversibility

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Hungary	1961 No specific provision, whether a sterilization on a consenting patient were considered an offense to the law dealing with intentional infliction of a corporal injury would depend on the existence and degree of the "social danger" of the act under the circumstances of the individual case.		- Seemingly medical reasons only					
Poland	1969 Legal under certain conditions		-On request and justified by physician			Strong emphasis on fully informed and mature consent of the person concerned.	Regular hospitals and clinics of the State Health Service	
Romania		1968 No specific provision, but the law dealing with intentional infliction of a corporal injury possibly in force for sterilization performed on purely contraceptive grounds.						

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Area of responsibility of the Economic Commission for Europe								
Northern Europe								
Denmark	1973 Legal		-On request	-25 years old and domiciled in Denmark -Under 25 years for eugenic reasons, if the parents, due to mental or physical defects, are unfit to give proper care to children -If social conditions make it desirable to prevent the birth of children.	Broad possibilities of vicarious sterilization of the husband or "defacto spouse"	- No Spousal consent required - If persons incapable of giving informed consent, application has to be submitted by guardian specially designated for the purpose. - If a person is under 25 years, authorization of a special committee is required. Possibility to appeal from the committee's decision.	-State or communal hospitals or clinics attached to such institutions. -Approved private hospitals -Vasectomies may be performed also by specially licensed physicians (since 1976)	

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
	1970							
Finland	Legal for some specific reasons after authorization of the State Medical Board.		- Eugenic - Serious limitations of the capacity of the person concerned to care for a child - Socio-economic - Extremely small possibility of preventing pregnancy by other means	18 yrs old except for particular congenital reasons.	Vicarious sterilization is strongly emphasized	-No spousal consent required. -If the person requesting sterilization is married: Spouse must be informed and couple must be advised "as to which of the two should preferably be sterilized--- from the standpoint of the family and the society".	Approved hospitals by licensed physicians.	

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Northern Europe	1975							
Iceland	Legal		On request	-25 years old -Under 25 years for eugenic reasons social conditions. Physical or mental health of parents. Report of two specialist physicians and approval of the chief medical officer are required for persons under 25 years.	Vicarious sterilization drawn by regulations	No spousal consent required for sterilization of an incompetent person requested by legal guardian has to be approved.	Hospitals approved for that purpose by the minister of health.	
Ireland	1861 No specific legal provisions, law dealing with an intentional infliction of a corporal injury is in force but seemingly physicians are not prosecuted under this provision.					Written consent of both spouses required in practice.		Male sterilization is carried out in one family planning clinic and on a very limited scale in some hospitals. Female sterilization is virtually unobtainable unless on medical grounds, when it is performed in a few hospitals.

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Norway	1977 Legal		On request	-25 years old and domiciled in the country. -Under 25 yrs., therapeutic reasons, eugenic reasons, mental health of parents, social conditions. -Under 18 years not allowed unless particularly imperative reasons -Authorization from a sterilization board required for persons under 25 years. Possibility to appeal to a Sterilization Council.	No provisions for vicarious sterilization of the spouse if he or she is younger than 25 yrs.	For persons under 20 yrs. or suffering from mental illness, guardian's consent is required.	-Public hospitals or approved private hospitals. - Sterilization of men may also be performed in other establishments, if approved for the purpose.	

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
	1975							
Sweden	Legal		On request	-25 years old and Swedish citizens or domiciled in Sweden - Under this age, authorization of the National Board of Health and Welfare is required under the following dispositions: Genetic reasons Health indications (for women) in conjunction with an application for sex determination -Minimum age: 18 years.	No sex differentiation	-Applicant must be accurately informed of the nature and consequences of the operation and maintains his or her request to be sterilized -No spousal consent required	For women, only in hospitals or approved institutions.	

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Kingdom	Voluntary sterilization is a lawful medical act 1972 Vasectomy legal (England and Wales) 1960's Female sterilization not regulated by statute but considered legal.		Family planning reason.	-No statutory requirement of a minimum age -Seemingly sterilization of a minor if performed for non-therapeutic reasons would be a violation of a bare human right	Only male sterilization regulated by law.	Spousal consent not required by law but in practice	-Any available facilities - Free of charge if carried out under the National Health Service	Widely practiced and considered as a valuable form of contraception
Europe								
	1977 No specific provisions but to cause intentionally loss of the function of an organ constitutes the crime of grave corporal injury, if "socially dangerous" under the circumstances						Institutions of State Health Care.	
		1950 No specific provision but law dealing with intentional infliction of a corporal injury is in force and applicable to voluntary sterilization.	Therapeutic					
		No information						

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
	197[illegible] Legal		Matter to be decided between patient and physician					Until recently sterilization was reported to be of little importance and having been used as means of birth control
		1[illegible]54 No specific provision but law dealing with intentional infliction of a corporal injury is in force and seemingly applicable to sterilization						
l		1[illegible]84 Law dealing with intentional infliction of a corporal injury is in force and applicable to sterilization.	Therapeutic					At present no information about the interpretation of the law following recent political change in the country.
ro		No information						

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
		1963 Illegal, "anyone who castrates or sterilizes another should be punished by imprisonment".						
...via	Legal in Slovenia-1977 in Croatia -1978		On request	-35 yrs. old -Under 35 years for therapeutic reasons, Genetic reasons Upon decision of a Commission. -Under the Croatian law minors presumably cannot be sterilized		-Only at the request of the person concerned -For legally incompetent person, at the request of parents or guardian, upon decision of a Commission.	-Eligible hospitals or in specially authorized medical establishements. -In Croatia, female sterilization must be performed in hospitals that have a gynecology and obstetrics department	
Europe								
	1974 Legal under certain conditions.		On request	-25 years old -Under this age if "the sterilization is not contrary to good morals or other reasons" -Seemingly not permitted under 18 years.	No sex differentiation	Spousal consent not required.	Performed as any other surgery by a physician on a consenting person	Denominational hospitals refuse to perform sterilization for non-medical reasons.

Table XIX.4. (Continued)

Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
Legal	Illegal						
1867 No specific provisions. Law dealing with intentional infliction of a corporal injury was in force but due to the reversal of views on family planning and after the decision of the Committee of ministers of the Council of Europe on Legislation affecting fertility and family planning (1975), voluntary sterilization can hardly be considered to be against "public order" or public policy.		On request	-Mature consenting person	No sex differentiation	Spousal consent required in practice	General surgery facilities	- Practiced occasionally - Official negative view on voluntary sterilization prevails.
No specific provisions. Law dealing with an intentional infliction of a corporal injury was in force but due to the reversal of views on family planning and after the decision of the Committee of ministers of Council of Europe on Legislation affecting fertility and family planning (1975), the doctrine criminalizing voluntary sterilization performed for family planning purposes may have lost its basis.		In an absence of any legal regulation, voluntary sterilization would be a matter to be decided between patient and physician		No sex differentiation			Sterilizations appear to be widespread.

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
ny, F.R. of	No specific provisions. A governmental bill of 1972 introducing regulation of voluntary sterilization has not been voted on in the parliament but several decisions of the Federal Supreme Court held that sterilization was not unlawful.		-Medical reasons. -Genetic reasons. -Serious social reasons equivalent to on request.	Mature person at least 25 years old.	No sex differentiation	Spousal consent not required		
enstein	No information							
ourg	1978 Seemingly legal since a comprehensive law on fertility related issues provided that the regional Counseling Centers, to be established and subsidized by the Government, shall provide information on ... "different methods of contraception and voluntary sterilization".							
	1967 No specific provision but law dealing with an intentional infliction of a corporal injury is not interpreted as applicable to a sterilization operation on a patient's request.							

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
is	1866 No specific provision, but voluntary sterilization is considered lawful as part of medical practice		On request (social indications)		No sex differentiation	Spousal consent not required.	- Regular medical facilities under medical insurance schemes. - Free of charge to all persons with either compulsory or voluntary medical insurance.	
ed	No specific provision. Seemingly law dealing with an intentional infliction of a corporal injury is not applicable to voluntary sterilization		- On request but tendency in medical practice to require in individual cases that the person concerned have either 2 or 3 children - In principle sterilization of women over 30 with 2 healthy children is approved by the Medical Society without further evaluation of the patient.		No sex differentiation	Spousal consent required.	In cases with medical indication charges are paid by the health insurance.	

Table A.XIX.4. (Continued)

Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
Legal	Illegal						
outh Asia (part)		Area of responsibility of the Economic Commission for Europe					
	1959 No specific provisions. Law dealing with an intentional infliction of a corporal injury is in force.						
-	No specific provisions, but seemingly law dealing with an intentional infliction of a corporal injury is in force	In general, sterilization is acceptable to medical profession only in cases of multiparae over the age of 30 and in cases where medically indicated.		- Few vasectomies - Mainly female sterilizations by minilaparotomy	Written, informed consent from both spouses	Some hospitals	
	1965 -1967 Sterilization for family planning purposes is a crime.	- Therapeutic - Hereditary diseases					

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
merica								
	1975 No specific provision but at present voluntary sterilization is considered as a lawful form of birth control: "Everyone is protected from criminal responsibility for performing a surgical operation for the benefit of the patient if it is reasonable to perform it having regard to all circumstances of the case"		On request (doctors should decide whether to perform a sterilization operation just as they would decide about any other request for surgical treatment)		No sex differentiation	No spousal consent required		As the practice of family planning sterilization became relatively common
tes	Legal in all States		On request	18 or 21 years.	No sex differentiation	-Few States required spousal consent -In exceptional cases where a minor would apply for sterilization parental consent is usually necessary -Consent of legal representative of legally incompetent adult is also required.	-In some States, in hospital -Public hospitals may not refuse to perform sterilizations for family planning reasons -Private hospitals are entitled to such refusals	Widely practiced as a method of family planning

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
of Soviet Socialist Republics								
ssian SSR		No information						
an SSR		No information						
	No specific provision; law dealing with an intentional infliction of a corporal injury is in force. Whether this provision can be applied to a sterilization operation requested by a patient may be determined by the application of the socialist legal concept of "social dangerousness".		Therapeutic					Voluntary sterilization as a method of family planning is not used.

Table A.XIX.4. (Continued)

Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
Legal	Illegal						
		Area of responsibility of the Economic Commission for Latin America					
	No information						
1868 o specific provision, ut law dealing with an ntentional infliction of a orporal injury is interpreted not applicable to voluntary terilization.		On request					Voluntary sterilization services are widely available but not widely used.
1968-1979 gal under certain conditions		On request but the woman must have several children.	32 years	No sex differentiation but althouth the female sterilization is regulated by the Ministry of Health, no regulations have been issued for male sterilization.	Informed consent and legally competent patient.	Hospitals of the National Health System.	
	No information						

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
an Rep.	No specific statutory provisions. Law dealing with an intentional infliction of a corporal injury may not be interpreted as applicable to sterilization operations (regulations issued by the Ministry of Public Health authorizing contraceptive female sterilizations)		- On request - Therapeutic reasons - Eugenic reasons.	-Women are to be 40 years. -40 years or over with at least one child -35 years or over with three or more children -30 years or over with five or more children -25 years or over with six or more children	Only female sterilization regulated by the Ministry of Health.	"Free and voluntary" consent required	Mainly public hospitals	

Table A.XIX.4. (Continued)

Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
Legal	Illegal						
	No specific provisions. Law dealing with an intentional infliction of a corporal injury is not applicable to voluntary sterilization because done in good faith, for the purposes or in the course of medical or surgical treatment.				Consent for surgical treatment may be given even against the will of the person concerned by the parents or guardian of a person younger than 18.		
	1835 No specific provision, but seemingly law dealing with an intentional infliction of a corporal injury is in force						
1953 No specific provisions. Law dealing with an intentional infliction of a corporal injury is not applied to surgical practice, including sterilization		On request	Patients over 35 years old are preferred	Male sterilization is rare in practice.	Spousal consent not required by law but encouraged in medical practice	Tubal ligations are performed free of charge in government hospitals	Seemingly widely practiced
	No information						
d	No information.						

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
	1950							
Trinidad and Tobago	No specific provisions. Law dealing with an intentional infliction of a corporal injury may not be applicable to sterilization operations on request, since the country has a government family planning program.		On request	Age not considered as important	Only sterilizations of women are reported.	Spousal consent required in practice		
Middle America								
Costa Rica	1970							
	No specific provisions. Law dealing with an intentional infliction of a corporal injury is not interpreted to be applicable to voluntary contraceptive sterilization.						Hospitals and private clinics	
	1974-1977							
El Salvador	No specific provisions. Law dealing with an intentional infliction of a corporal injury can hardly be applicable to sterilization of consenting patients, as in 1974 the Ministry of Health and Social Welfare issued regulations governing voluntary sterilizations.				Vasectomy and female sterilization			Sterilization is practiced with the support of the Ministry of Health and Social Welfare which has requested equipment for clinics for vasectomy and for female sterilization.

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Guatemala	1936 No specific provisions. Law dealing with an intentional infliction of a corporal injury cannot be applied to voluntary sterilization.				No sex differentiation	Spousal consent required	- State and private institutions - Facilities operated under the Association for Family Welfare	The Government has authorized various methods of family planning, voluntary sterilization is one of them.
Honduras	1964 Law dealing with an intentional infliction of a corporal injury is not applicable, since medical Fundamental Law provided that voluntary sterilization could be performed under certain conditions.		On request			-Written authority of the person concerned -Decided by three competent physicians.		
Mexico	1931 No specific provisions. Law dealing with an intentional infliction of a corporal injury is not interpreted to be applicable to voluntary surgical sterilization.		On request	Age of Majority	No sex differentiation	Spousal consent required in medical practice.	Hospitals, sanitariums and clinics approved by the Ministry of Health and Welfare	The Ministry of Health and Welfare prohibits any type of publicity in support of voluntary sterilization outside the official family planning programs

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
		1949						
Nicaragua		Seemingly, law dealing with an intentional infliction of a corporal injury is applicable to sterilization operations.						
	1961							
Panama	Legal under certain conditions		-On request if she has at least five living children and difficult social and economic conditions - Health reasons - Eugenic reasons Sterilization has to be authorized by the Sterilization Board	In practice, 26 yrs.	-The law regulates female sterilization only -Virtually no vasectomies	Spousal consent required in practice	Hospitals and clinics	

Table A.XIX.4. (Continued)

Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
Legal	Illegal						
Temperate South America							
Argentina	1921 No specific provisions. Law dealing with an intentional infliction of a corporal injury is in force and seemingly applicable to voluntary sterilization.						
Chile	1975 Sterilization is not to be considered as a method of fertility regulation and on other than medical grounds might be considered a crime of corporal injury	Therapeutic reasons only			Written consent by the couple required	Hospitals	- Physicians had been prohibited from performing non-therapeutic sterilization by the Chilean Sanitary Code. - In 1974, the Ministry of Health authorized sterilizations on socio-economic grounds - In 1975, a resolution of the Minister of Health repealed "all earlier provisions on the subject"

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Uruguay	No specific provision. Law dealing with an intentional infliction of a corporal injury is in force but there is a provision on justification by the injured person's consent "causing bodily injury with the consent of the injured person is not punishable...".							
Tropical South America								
Bolivia		1972 Law dealing with an intentional infliction of a corporal injury is in force. But it is a less punishable offense to cause a corporal injury to another person with his or her consent						
Brazil	1940-1969 Law dealing with an intentional infliction of a corporal injury is in force but seemingly not applicable to surgical operation, including tubal ligation.		On request (in practice) The surgeon usually requests opinion of three other physicians.		No sex differentiation but mostly female sterilization	Spousal consent required in medical practice	Few public hospitals in Rio de Janeiro perform sterilization free.	Contraceptive voluntary Sterilization is practiced.

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
	1936							
Columbia	No specific provisions. Law dealing with an intentional infliction of a corporal injury is in force, but Columbian legal practice does not apply that provision to voluntary sterilizations performed on request.		On request	35 years and have more than two children, with at least one child of each sex.	Vasectomy practiced by the Family Planning Association (Profamilia)	Spousal consent required in medical practice	- The private association profamilia has urban clinics as well as mobile programs which are intended to reach out into the rural areas. - The Ministry of Health performs sterilization in its regional hospitals.	Sterilization is widely practiced.
	1938							
Ecuador	Law dealing with an intentional infliction of a corporal injury is in force but this provision may not be interpreted as applicable to sterilization operation performed on consenting patients as the Medical Ethics Code of Ecuador permits contraceptive sterilization in certain cases.		On request - Medical reasons - Eugenic reasons	25 years (women) and must have at least three living children	No sex differentiation			
	1949							
Guyana	No specific provisions. Law dealing with an intentional infliction of a corporal injury is in force but cannot be applied to sterilization operation on consenting patients as such acts constitute criminal offenses only if committed "unlawfully and maliciously".							

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Paraguay		1909 No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and seemingly applicable to voluntary sterilization						
Peru	1924 No specific provisions; law dealing with an intentional infliction of a corporal injury is in force; but voluntary sterilizations performed by specialist and done with full consent of the patient are not prosecuted.					Spousal consent required in practice	- Private clinics and hospitals - To be performed by surgeons and urology specialists	
Surinam	No information							
Venezula		1971 The Code of Medical Ethics provides that sterilization operations may be performed only for medical or eugenic reasons	-Medical reasons -Eugenic reasons					

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Western South Asia		Area of responsibility of the Economic Commission for Western Asia						
Bahrain		1955 Law dealing with an intentional infliction of a corporal injury is in force and applicable to contraceptive sterilization.						
Democratic Yemen		1969 No legal information but Islamic religious law is opposed to sterilization unless performed for health and eugenic reasons.						
Iraq		1969 No legal information but Islamic religious law is opposed to sterilization unless performed for health and eugenic reasons.						
Jordan		1965 No specific provisions. As the Criminal Code does not include any prohibition covering voluntary sterilization the operation may be performed lawfully. But the Islamic religion of the community is opposed to sterilization unless performed for eugenic or health purposes.	-Medical reasons -Eugenic reasons	Usually 30 years	Female sterilization only	Spousal consent required in medical practice	Performed by specialized physicians in government or private hospitals	

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Kuwait	1960 No legal information but Islamic religious law is opposed to sterilization unless performed for health and eugenic reasons		-Medical reasons -Eugenic reasons		Female sterilization mainly	Consent of both spouses required		
Lebanon	1943 Law dealing with an intentional infliction of a corporal injury is in force. But in practice contraceptive sterilizations are performed		On request	-Minimum age for women, 30 years and must have at least three children	Both male and female sterilizations performed	Spousal consent required in medical practice.		Promoted by the Family Planning Association.
Oman	1966 Since 1966, the main source of law, had been Islamic religious law which is opposed to voluntary sterilization							
Qatar	1971 No information on the legal status of voluntary sterilization but presumably law dealing with an intentional infliction of a corporal injury is in force and applicable to contraceptive sterilization.							

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Saudi Arabia		No specific provisions and no criminal code. The basic legal source is the Islamic religious law which is opposed to voluntary sterilization	-Medical reasons -Eugenic reasons					
Syrian Arab Republic		1949 Law dealing with an intentional infliction of a corporal injury is in force and seemingly applicable to voluntary sterilization. Islamic law deals with matters of personal status.						
United Arab Emirates		No information						
Yemen		The main source of law is Islamic religious law. Thus voluntary sterilization is illegal.						

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Area of responsibility of the Economic and Social Commission for Asia and the Pacific								
China								
China	Legal without medical indications and promoted as an extensively used method of birth control		On request	-	Tubal ligations more frequent than vasectomies	No spousal consent	- Publicly funded health services for State employees - Co-operative services for the rest of the population - Free as part of planned birth service	Very widely practiced as method of family planning
Japan	1948							
Japan	Legal for genetic reasons Life of mother (endangered by pregnancy or delivery) Mother has several children and her health seems to be seriously affected by the delivery		-Genetic -Life of woman -Health of woman	Minor can be sterilized for genetic reasons	Tubal ligations more frequent than vasectomies	Spousal or partner's consent is requested	To be performed by surgeon in hospitals and clinics	Widely practiced mainly for protection of the mother's life and health
Other East Asia								
D.P.R. of Korea		1950 Possibly assimilated to the law dealing with an intentional infliction of corporal injury						

Table A.XIX.A. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/Incentives	Remarks
	Legal	Illegal						
Mongolia		1969 No specific provision assimilated to the law dealing with intentional infliction of a corporal injury						Sterilization for family planning purposes does not seem to be practiced
R. of Korea	1973 No specific provision, but law dealing with intentional infliction of a corporal injury cannot be applied		On request as a method of family planning	-	Both tubal ligations and vasectomies	Spousal consent not required by law but in practice	- Public health centers - Private clinics - Financial Assistance for those adopting sterilization as a fertility control measure.	Officially encouraged and widely practiced
Eastern S.Asia								
Burma		1965 Voluntary sterilization, even therapeutic, is a crime, if it is performed without authorization of a board. The person who consented to his/her sterilization commits an offense as well.						
Dem. Kampuchea	No information.							
Indonesia		1946-1978 Neither specific provision nor clarified interpretation of the criminal code, family law or guidelines of State Policy Indonesia has an Association for Voluntary Sterilization since 1974.	Usually on medical grounds.	-	Both tubal ligations and vasectomies	Written spousal consent	Hospitals and clinics	

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Lao P.D.R.	1922-1965 Law of 1922, extensively amended in 1965 is in force but no information.							To a certain extent, supported by government at a earlier time, but government minimized its support
Malaysia	1948 No specific provision, but law dealing with intentional infliction of a corporal injury is in force except if done in good faith.		Medical socio-economic family planning	-	Tubal ligations more frequent than vasectomies	Spousal consent required in medical practice	- Physicians working in the state health care service - In private office - Those working for the National Family Planning Board	Practised as a method of family planning.
Philippines	1976 legal by presidential decree		On request	-		Spousal consent required	- Public and private hospitals and clinics - Medical fees regulated.	
Singapore	1974 Legal					- Spousal consent not required - Consent of the person concerned and of a parent or guardian for those under 21 and unmarried.	- Registered practitioner - Government hospital or approved institution.	Intensively promoted by the government including a system of incentives/ disincentives

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
S. R. of Vietnam	No legal information							It is reported that in 1977 a comprehensive program has been started, including both male and female sterilization, generally for maternal and child care reasons.
Thailand	1962 Administrative regulations of the Ministry of Public Health regulate voluntary sterilization incorporated in the national family planning program		- Economic and living conditions (to be determined by the director of the hospitals) - Eugenic - Family limitation motives		Both male and female sterilization	Spousal consent required	Government hospitals and health centers	- As a method of fertility control, widespread in the country. - In practice, it is required that the couple have two or more living children and that if they have only two, the younger should be at least one year old.
Middle S. Asia								
Afghanistan		1976 No specific provision assimilated to law dealing with intentional infliction of a corporal injury						

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/Incentives	Remarks
	Legal	Illegal						
Bangladesh	1976 Legal since law dealing with intentional infliction of a corporal injury is interpreted so as not to be applicable to voluntary sterilization		On request but couples are advised to have at least two children	-	Vasectomies more frequent than tubal ligations	No information	- Clinics set up by the government or hospitals for female sterilization - Mobile clinics	Strongly promoted by the State and widely practiced
Bhutan	No information							
India	1860 Legal, criminal code provides penalities for intentionally causing "hurt" but nothing if it is caused to any person for which benefit it is done in good faith.		On request	Male: No less than 25 years. Female: No less than 20 years. No more than 45 years.	Both vasectomies and tubal ligations are performed	Voluntary informed Consent is a prerequisite	- Government institutions - Institutions of local hospitals - Voluntary organizations recognized for the purpose of family planning	Strongest governmental support since voluntary sterilization is recognized as one of the most important methods of slowing population growth and improving the socio-economic situation of many families
Iran (situation in force before Iran became an Islamic Republic in 1979)	1976 Legal under certain conditions a/		On request but - unmarried persons have to be over 30 years - Married people: either has two or more children or both partners are over 25 years.			Spousal consent required	Fully equipped hospitals and clinics	The number of sterilizations is small.

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Maldives	No information							
Pakistan	1860 Legal, since law dealing with intentional infliction of a corporal injury is interpreted so as not to be applicable to sterilization for family planning purposes.		On request, but woman must have at least 3 children one of whom must be a boy.			Spousal consent required for female sterilization	Post-partum clinics	For many years promoted by government
Nepal	1963 No specific provision but there is no law prohibiting voluntary sterilization or laying down any conditions for it. Sterilization is an integral part of the nation's family planning program.		On request					
Sri Lanka	1883 No specific provision, but legal since law dealing with intentional infliction of a corporal injury is interpreted so as not to be applicable to voluntary sterilization on request of a patient		Family planning motive of a consenting patient				- Hospitals and clinics - Cost covered by the government's family planning program	-Widely practiced -Incentive schemes to encourage it in some areas of the country.

Table A.XIX.4. (Continued)

	Legality		Grounds	Age	Type of Sterilization	Consent	Facilities/Incentives	Remarks
	Legal	Illegal						
Australia/New Zealand								
Australia	Legal, but no specific statutory provision. The present uncertain legal situation may inhibit some doctors from proceeding.		No specific ground.	-	Both vasectomies and tubal ligations are performed.	Spousal consent usually requested by physician.	Clinics and hospitals	
New Zealand	Legal 1977		On request	Only adults	Both vasectomies and tubal ligations are performed.	- No other person can consent to a sterilization on behalf of a minor - Unlawful to condition, a loan, or employment, fringe benefits or a disposition of a property on a person's sterility.	-In-patients and out- patients facilities in appropriate institutions.	Widely practiced
Melanesia								
Papua New Guinea.	No specific provision but anyone performing sterilization at a patient's request is exempted from criminal responsibility 1899							No specific information about sterilization but a nationwide expansion of the family program was approved by the government.
Solomon Islands	No information							

Table A.XIX.4. (Continued)

	Legality		Ground	Age	Type of Sterilization	Consent	Facilities/incentives	Remarks
	Legal	Illegal						
Micronesia-Polynesia								
Fiji	1945 No specific provision, but law dealing with intentional infliction of a corporal injury is not construed so as to prohibit voluntary sterilization.		On request	Probably restricted to married people.	Both tubal ligations and vasectomies are performed	Both spouses written consent required before a medical officer	-Family planning clinics and other medical facilities	
Kiribati	No information							
Nauru	No information							
Samoa	No information							
Tonga	No information							
Tuvalu	No information							

a/ The law legalizing voluntary sterilization on both medical and social grounds have now been repealed

Sources: 1. United Nations Population Policy Inquiries and Population Division, Population Policy Data Bank.
2. United Nations Fund for Population Activities 1979, Survey of Laws on Fertility Control.
3. Jean-Paul Sardon, La stérilisation dans le monde. II. Données statistiques, Population, numéro 5, Mai-Juin, Revue bimestrielle de l'institut national d'études démographiques

Table A.XX.1. Governments perceptions of the acceptability of international immigration, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980

Immigration significant			Immigration not significant		
Too low	Satisfactory	Too high	Immigration desired	Situation satisfactory	
Area of responsibility of Economic Commission for Africa					
		Eastern Africa			
	Uganda Zimbabwe	Djibouti Somalia		Burundi Comoros Ethiopia Kenya Madagascar Malawi Mauritius Mozambique Rwanda Seychelles United Republic of Tanzania Zambia	
		Middle Africa			
Equatorial Guinea	Zaire	Gabon		Angola Central African Republic Chad Congo Sao Tome and Principe United Republic of Cameroon	
		Northern Africa			
	Libyan Arab Jamahiriya	Sudan		Algeria Egypt Morocco Tunisia	
		Southern Africa			
South Africa				Botswana Lesotho Swaziland	
		Western Africa			
	Liberia	Ghana Ivory Coast		Benin Cape Verde Gambia Guinea Guinea Bissau Mali Mauritania Niger Nigeria Senega. Sierra Leone Togo Upper Volta	
Total: 2	5	6	-	38	51

Table A.XX.1 (Continued)

Immigration significant			Immigration not significant	
Too low	Satisfactory	Too high	Immigration desired	Situation satisfactory
Area of responsibility of Economic Commission for Latin America				
		Caribbean		
		Bahamas		Barbados Cuba Dominica Dominican Republic Grenada Haiti Jamaica Saint Lucia Saint Vincent and the Grenadines Trinidad and Tobago
		Middle America		
		Costa Rica		El Salvador Guatemala Honduras Mexico Nicaragua Panama
		Temperate South America		
Argentina				Chile Uruguay
		Tropical South America		
		Venezuela	Bolivia Ecuador Guyana	Brazil Colombia Paraguay Peru Suriname
Total: 1	-	1	3	25 30

Table A.XX.1. (Continued)

Immigration significant			Immigration not significant		
Too low	Satisfactory	Too high	Immigration desired	Situation satisfactory	
		Area of responsibility of Economic Commission for Europe			
		Eastern Europe			
				Bulgaria Czechoslovakia German Democratic Republic Hungary Poland Romania	
		Northern Europe			
	Norway Sweden	United Kingdom			
				Denmark Finland Iceland Ireland	
		Southern Europe			
		San Marino		Albania Greece Holy See Italy Malta Portugal Spain Yugoslavia	
		Western Europe			
	Austria Germany, Federal Republic of Liechtenstein Luxembourg Monaco Switzerland	France Netherlands		Belgium	
		Western South Asia (part)			
Israel					
				Cyprus Turkey	
		Northern America			
	Canada	United States of America			
		Union of Soviet Socialist Republics			
				Byelorussian SSR Ukrainian SSR USSR	
Total: 1	9	5	-	24	39

Table A.XX.1. (Continued)

Immigration significant			Immigration not significant		
Too low	Satisfactory	Too high	Immigration desired	Situation satisfactory	
		Area of responsibility of Economic Commission for Western Asia			
		Western South Asia			
Saudi Arabia	Bahrain Lebanon Oman Qatar	Kuwait United Arab Emirates	Iraq	Democratic Yemen Jordan Syrian Arab Republic Yemen	
Total: 1	4	2	1	4	12

Table A.XX.1 (Continued)

Immigration significant			Immigration not significant		
Too low	Satisfactory	Too high	Immigration desired	Situation satisfactory	
		Area of responsibility of Economic and Social Commission for Asia and the Pacific			
		China		China	
		Japan		Japan	
		Other East Asia			
				Democratic Peopl Republic of Kor	
				Mongolia	
				Republic of Kore	
		Eastern South Asia			
		Malaysia		Burma	
		Thailand		Democratic Kampuchea	
				Indonesia	
				Lao People's Democratic Republic	
				Philippines	
				Singapore	
				Viet Nam	
		Middle South Asia			
	Bhutan	Nepal		Afghanistan	
		Pakistan		Bangladesh	
				India	
				Iran	
				Maldives	
				Sri Lanka	
		Australia and New Zealand			
Australia				New Zealand	
		Melanesia			
				Papua New Guine	
				Solomon Islands	
		Micronesia-Polynesia			
	Nauru	Samoa		Fiji	
				Kiribati	
				Tonga	
				Tuvalu	
Total: 1	2	5	-	25	33
Developed countries: 1	9	5	-	24	39
Developing countries: 5	11	16	4	90	126
Total: 6	20	21	4	114	165

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XX.2. Governments' policies with respect to international immigration, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980

Government policies in favour of				
higher rate	maintaining current rate but subject to strict control	curbing immigration in future but maintaining already established immigrant population	Immigration perceived to be not demographically significant and desirable or not desirable	
Area of responsibility of Economic Commission for Africa				
		Eastern Africa		
	Djibouti Uganda Zimbabwe	Somalia	Burundi Comoros Ethiopia Kenya Madagascar Malawi Mauritius Mozambique Rwanda Seychelles United Republic of Tanzania Zambia	
		Middle Africa		
Equatorial Guinea	Zaire	Gabon	Angola Central African Republic Chad Congo Sao Tome and Principe United Republic of Cameroon	
		Northern Africa		
	Libyan Arab Jamahiriya	Sudan	Algeria Egypt Morocco Tunisia	
		Southern Africa		
South Africa			Botswana Lesotho Swaziland	
		Western Africa		
	Liberia	Ghana Ivory Coast	Benin Cape Verde Gambia Guinea Guinea Bissau Mali Mauritania Niger Nigeria Senegal Sierra Leone Togo Upper Volta	
Total: 2	6	5	38	51

Table A.XX.2 (Continued)

Government policies in favour of			
higher rate	maintaining current rate but subject to strict control	curbing immigration in future but maintaining already established immigrant population	Immigration perceived to be not demographically significant and desirable or not desirable
Area of responsibility of Economic Commission for Europe			
		Eastern Europe	
			Bulgaria Czechoslovakia German Democratic Republic Hungary Poland Romania
		Northern Europe	
		Norway Sweden United Kingdom	Denmark Finland Iceland Ireland
		Southern Europe	
		San Marino	Albania Greece Holy See Italy Malta Portugal Spain Yugoslavia
		Western Europe	
		Austria France Germany, Federal Republic of Liechtenstein Luxembourg Monaco Netherlands Switzerland	Belgium
		Western South Asia (part)	
Israel			Cyprus Turkey
		Northern America	
	Canada United States of America		
		Union of Soviet Socialist Republics	
			Byelorussian SSR Ukrainian SSR USSR
Total: 1	2	12	24 39

Table A.XX.2 (Continued)

Government policies in favour of				
higher rate	maintaining current rate but subject to strict control	curbing immigration in future but maintaining already established immigrant population	Immigration perceived to be not demographically significant and desirable or not desirable	
Area of responsibility of Economic Commission for Latin America				
		Caribbean		
	Bahamas		Barbados Cuba Dominica Dominican Republic Grenada Haiti Jamaica Saint Lucia Saint Vincent and and the Grenadines Trinidad and Tobago	
		Middle America		
	Costa Rica		El Salvador Guatemala Honduras Mexico Nicaragua Panama	
		Temperate South America		
Argentina			Chile Uruguay	
		Tropical South America		
Bolivia Ecuador Guyana		Venezuela	Brazil Colombia Paraguay Peru Suriname	
Total: 4	2	1	23	30

Table A.XX.2 (Continued)

Government policies in favour of				
higher rate	maintaining current rate but subject to strict control	curbing immigration in future but maintaining already established immigrant population	Immigration perceived to be not demographically significant and desirable or not desirable	
Area of responsibility of Economic Commission for Western Asia				
Western South Asia				
Saudi Arabia	Bahrain Lebanon Oman Qatar	Kuwait United Arab Emirates	Democratic Yemen Iraq Jordan Syrian Arab Republic Yemen	
Total: 1	4	2	5	12

Government policies in favour of				
higher rate	maintaining current rate but subject to strict control	curbing immigration in future but maintaining already established immigrant population	Immigration perceived to be not demographically significant and desirable or not desirable	
Area of responsibility of Economic and Social Commission for Asia and the Pacific				
		China	China	
		Japan	Japan	
		Other East Asia		
			Democratic People's Republic of Korea Mongolia Republic of Korea	
		Eastern South Asia		
		Malaysia Thailand	Burma Democratic Kampuchea Indonesia Lao People's Democratic Republic Philippines Singapore Viet Nam	
		Middle South Asia		
	Bhutan	Nepal Pakistan Iran	Afghanistan Bangladesh India Maldives Sri Lanka	
		Australia and New Zealand		
Australia			New Zealand	
		Melanesia		
			Papua New Guinea Salomon Islands	
		Micronesia-Polynesia		
	Nauru Samoa		Fiji Kiribati Tonga Tuvalu	
Total: 1	3	5	24	33
Developed countries: 1	2	12	24	39
Developing countries 8	15	13	90	126
Total: 9	17	25	114	165

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XX.3. Governments' perceptions of the acceptability of international emigration, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980

Emigration significant			Emigration not significant	
Too low	Satisfactory	Too high	Emigration desired	Situation satisfactory
Area of responsibility of Economic Commission for Africa				
		Eastern Africa		
	Comoros	Seychelles	Rwanda	Burundi
	Malawi	Somalia		Djibouti
	Mauritius			Ethiopia
	Mozambique			Kenya
				Madagascar
				Uganda
				United Republic of Tanzania
				Zambia
				Zimbabwe
		Middle Africa		
	Angola			
	Chad			Central African Republic
				Congo
				Equatorial Guinea
				Gabon
				Sao Tome and Principe
				United Republic of Cameroon
				Zaire
		Northern Africa		
Algeria	Egypt			
	Morocco			Libyan Arab Jamahiriya
	Tunisia			Sudan
		Southern Africa		
	Lesotho	Botswana		
	Swaziland			South Africa
		Western Africa		
	Cape Verde	Guinea		
	Mali	Upper Volta		Benin
	Mauritania			Gambia
	Senegal			Ghana
				Guinea-Bissau
				Ivory Coast
				Liberia
				Niger
				Nigeria
				Sierra Leone
				Togo
Total: 1	15	5	1	29 51

Table A.XX.3. (Continued)

Emigration significant			Emigration not significant		
Too low	Satisfactory	Too high	Emigration desired	Situation satisfactory	
		Area of responsibility of Economic Commission for Europe			
		Eastern Europe			
				Bulgaria Czechoslovakia German, Democratic Republic Hungary Poland Romania	
		Northern Europe			
		Finland Ireland		Denmark Iceland Norway Sweden United Kingdom	
		Southern Europe			
Portugal	Malta	Greece Italy Spain Yugoslavia		Albania Holy See San Marino	
		Western Europe			
Netherlands				Austria Belgium France Germany, Federal Republic of Liechtenstein Luxembourg Monaco Switzerland	
		Western South Asia (part)			
Turkey		Cyprus		Israel	
		Northern America			
				Canada United States of America.	
		Union of Soviet Socialist Republics			
				Byelorussian SSR Ukrainian SSR USSR	
Total: 3	1	7	-	28	39

Table A.XX.3. (Continued)

Emigration significant			Emigration not significant	
Too low	Satisfactory	Too high	Emigration desired	Situation satisfactory
Area of responsibility of Economic Commission for Latin America				
		Caribbean		
	Barbados Cuba Dominican Republic Grenada Haiti	Jamaica Trinidad and Tobago		Bahamas Dominica Saint Lucia Saint Vincent and the Grenadines
		Middle America		
	El Salvador Nicaragua	Honduras Mexico		Costa Rica Guatemala Panama
		Temperate South America		
		Uruguay		Argentina Chile
		Tropical South America		
		Bolivia Colombia Paraguay Suriname		Brazil Ecuador Guyana Peru Venezuela
Total: -	7	9	-	14 30

Table A.XX.3 (Continued)

Emigration significant			Emigration not significant	
Too low	Satisfactory	Too high	Emigration desired	Situation satisfactory
		Area of responsibility of Economic Commission for Western Asia		
		Western South Asia		
	Democratic Yemen Yemen	Jordan	Syrian Arab Republic	Bahrain Iraq Kuwait Lebanon Oman Qatar Saudi Arabia United Arab Emirates
Total: -	2	1	1	8 12

Table A.XX.3 (Continued)

Emigration significant			Emigration not significant		
Too low	Satisfactory	Too high	Emigration desired	Situation satisfactory	
		Area of responsibility of Economic and Social Commission for Asia and the Pacific			
		China		China	
		Japan		Japan	
		Other East Asia			
Republic of Korea				Democratic People's Republic of Korea	
				Mongolia	
		Eastern South Asia			
	Democratic Kampuchea		Malaysia	Burma	
	Viet Nam			Indonesia	
				Lao People's Democratic Republic	
				Philippines	
				Singapore	
				Thailand	
		Middle South Asia			
Pakistan	Nepal	Afghanistan		Bangladesh	
	Sri Lanka			Bhutan	
				India	
				Iran	
				Maldives	
		Australia and New Zealand			
		New Zealand		Australia	
		Melanesia			
				Papua New Guinea	
				Salomon Islands	
		Micronesia-Polynesia			
	Tonga	Fiji		Kiribati	
				Nauru	
				Samoa	
				Tuvalu	
Total: 2	5	3	1	22	33
Developed countries: 2	1	7	-	29	39
Developing countries: 4	29	18	3	72	126
Total: 6	30	25	3	101	165

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XX.4. Governments' policies with respect to international emigration, by areas of responsibility of regional commissions, geographical regions and level of development, July 1980

Government policies in favour of			Emigration perceived to be not demographically significant and desirable or not desirable
higher rate	maintaining current rate	curbing emigration in future	
	Area of responsibility of Economic Commission for Africa		
		Eastern Africa	
	Comoros Malawi Mauritius Mozambique Seychelles	Somalia	Burundi Djibouti Ethiopia Kenya Madagascar Rwanda Uganda United Republic of Tanzania Zambia Zimbabwe
		Middle Africa	
	Angola Chad		Central African Republic Congo Equatorial Guinea Gabon Sao Tome and Principe United Republic of Cameroon Zaire
		Northern Africa	
Algeria	Egypt Morocco Tunisia		Libyan Arab Jamahiriya Sudan
		Southern Africa	
	Lesotho Swaziland	Botswana	South Africa
		Western Africa	
	Mali Mauritania Senegal	Guinea Upper Volta	Benin Cape Verde Gambia Ghana Guinea Bissau Ivory Coast Liberia Niger Nigeria Sierra Leone Togo
Total: 1	15	4	31 51

Table A.XX.4. (Continued)

Government policies in favour of			
higher rate	maintaining current rate	curbing emigration in future	Emigration perceived to be not demographically significant and desirable or not desirable
Area of responsibility of Economic Commission for Europe			
		Eastern Europe	
			Bulgaria
			Czechoslovakia
			German Democratic Republic
			Hungary
			Poland
			Romania
		Northern Europe	
		Finland	Denmark
		Ireland	Iceland
			Norway
			Sweden
			United Kingdom
		Southern Europe	
Portugal	Malta	Greece	Albania
		Italy	Holy See
		Spain	San Marino
		Yugoslavia	
		Western Europe	
Netherlands			
			Austria
			Belgium
			France
			Germany, Federal Republic of
			Liechtenstein
			Luxembourg
			Monaco
			Switzerland
		Western South Asia (part)	
Turkey		Cyprus	Israel
		Northern America	
			Canada
			United States of America
		Union of Soviet Socialist Republics	
			Byelorussian SSR
			Ukrainian SSR
			USSR
Total: 3	1	7	28 39

Table A.XX.4 (Continued)

Government policies in favour of			
higher rate	maintaining current rate	curbing emigration in future	Emigration perceived to be not demographically significant and desirable or not desirable
Area of responsibility of Economic Commission for Latin America			
		Caribbean	
	Barbados Dominican Republic Grenada Haiti	Cuba Jamaica Trinidad and Tobago	Bahamas Dominica Saint Lucia Saint Vincent and the Grenadines
		Middle America	
	El Salvador Nicaragua	Honduras Mexico	Costa Rica Guatemala Panama
		Temperate South America	
		Uruguay	Argentina Chile
		Tropical South America	
		Bolivia Colombia Paraguay Suriname	Brazil Ecuador Guyana Peru Venezuela
Total: -	6	10	14 30

Table XX.4. (Continued)

Government policies in favour of			Emigration perceived to be not demographically significant and desirable or not desirable
higher rate	maintaining current rate	curbing emigration in future	
	Area of responsibility of Economic Commission for Western Asia		
	Western South Asia		
	Democratic Yemen Yemen	Jordan	Bahrain Iraq Kuwait Lebanon Oman Qatar Saudi Arabia Syrian Arab Republic United Arab Emirates
Total: -	2	1	9 12

Table A.XX.4. (Continued)

Government policies in favour of			Emigration perceived to be not demographically significant and desirable or not desirable
higher rate	maintaining current rate	curbing emigration in future	
Area of responsibility of Economic and Social Commission for Asia and the Pacific			
		China	China
		Japan	Japan
		Other East Asia	
Republic of Korea			Democratic People's Republic of Korea Mongolia
		Eastern South Asia	
	Viet Nam	Democratic Kampuchea	Burma Indonesia Lao People's Democratic Republic Malaysia Philippines Singapore Thailand
		Middle South Asia	
Pakistan	Nepal Sri Lanka	Afghanistan	Bangladesh Bhutan India Iran Maldives
		Australia and New Zealand	
		New Zealand	Australia
		Melanesia	
			Papua New Guinea Salomon Islands
		Micronesia-Polynesia	
	Tonga	Fiji	Kiribati Nauru Samoa Tuvalu
Total: 2	4	4	23 33
Developed countries: 2	1	7	29 39
Developing countries: 4	27	19	76 126
Total: 6	28	26	105 165

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XXI.I. Governments' policies with respect to internal migration and configuration of settlement, by perception of the acceptability of spatial distribution of population by areas of responsibility of regional commissions, geographical regions and level of development, July 1980

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inapropriate	Accelerate	No inter-vention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
Area of responsibility of the Economic Commission for Africa											
Eastern Africa											
Burundi	-	x	-	-	x	-	-	-	x	-	-
Comoros	-	x	-	-	x	-	-	x	-	-	-
Djibouti	-	x	-	-	-	-	x	-	x	-	-
Ethiopia	-	-	x	-	-	x	-	-	x	-	-
Kenya	-	-	x	-	-	x	-	-	x	-	-
Madagascar	-	-	x	-	-	x	-	-	x	-	x
Malawi	-	x	-	-	-	x	-	-	-	-	-
Mauritius	-	-	x	-	-	x	-	-	-	-	x
Mozambique	-	-	x	-	-	-	x	-	-	-	x
Rwanda	-	-	x	-	x	-	-	-	x	-	-
Seychelles	-	-	x	-	-	x	-	-	-	-	-
Somalia	-	-	x	-	-	x	-	x	-	-	-
Uganda	-	x	-	-	-	x	-	-	x	-	-
United Rep. of Tanzania	-	-	x	-	-	x	-	x	-	-	-
Zambia	-	-	x	-	-	x	-	-	-	-	x
Zimbabwe	-	x	-	-	-	x	-	-	x	-	-
Middle Africa											
Angola	-	-	x	-	-	-	x	-	-	-	x
Central African Empire	-	-	x	-	-	-	x	-	x	-	-
Chad	-	x	-	-	x	-	-	x	-	-	-
Congo	-	-	x	-	-	x	-	-	-	-	-
Equatorial Guinea	-	-	x	-	-	-	x	-	x	-	-
Gabon	-	-	x	-	-	x	-	-	-	-	-
Sao Tome and Principe	-	-	x	-	-	x	-	-	-	-	x
United Rep. of Cameroon	-	-	x	-	-	x	-	-	-	-	x
Zaire	-	-	x	-	-	x	-	-	x	-	-

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
Northern Africa											
Algeria	-	-	x	-	-	x	-	-	-	-	x
Egypt	-	-	x	-	-	x	-	-	-	-	x
Libyan Arab Jamahiriya	-	x	-	-	-	x	-	-	-	-	x
Morocco	-	-	x	-	-	x	-	x	-	-	x
Sudan	-	-	x	-	-	x	-	-	x	-	-
Tunisia	-	x	-	-	-	x	-	-	-	-	x
Southern Africa											
Botswana	-	-	x	-	-	x	-	-	-	-	x
Lesotho	-	x	-	-	x	-	-	x	-	-	x
South Africa	-	x	-	-	-	-	x	-	-	-	x
Swaziland	-	-	x	-	-	x	-	x	-	-	x
Western Africa											
Cape Verde	-	-	x	-	x	-	-	x	-	-	-
Benin	-	-	x	-	x	-	-	-	x	-	-
Gambia	-	x	-	-	-	x	-	x	-	-	-
Ghana	-	-	x	-	-	x	-	-	-	-	x
Guinea	-	x	-	-	x	-	-	x	-	-	-
Guinea-Bissau	-	-	x	-	-	-	x	-	-	-	-
Ivory Coast	-	-	x	-	-	x	-	-	-	-	x
Liberia	-	-	x	-	-	x	-	-	-	-	x
Mali	-	-	x	-	-	x	-	-	-	-	x
Mauritania	-	-	x	-	-	x	-	x	-	-	-
Niger	-	-	x	-	x	-	-	-	x	-	-
Nigeria	-	-	x	-	-	x	-	x	-	-	-
Senegal	-	-	x	-	-	x	-	x	-	-	-
Sierra Leone	-	x	-	-	x	-	-	-	-	-	x
Togo	-	-	x	-	-	x	-	-	-	-	x
Upper Volta	-	-	x	-	x	-	-	-	x	-	-
Total	0	14	37	0	11	33	7	14	16	0	21
		51			51				51		

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
Area of responsibility of the Economic Commission for Europe											
Eastern Europe											
Bulgaria	-	x	-	-	-	x	-	-	-	x	-
Czechoslovakia	x	-	-	-	-	x	-	-	-	x	-
German Dem. Republic	x	-	-	-	-	x	-	-	-	x	-
Hungary	x	-		-	-	x	-	-	-	x	-
Poland	-	x	-	-	-	x	-	-	-	x	-
Romania	-	x	-	-	-	x	-	-	-	x	-
										x	-
Northern Europe											
Denmark	x	-	-	-	x	-	-	x	-	-	-
Finland	-	x	-	-	-	x	-	-	-	x	-
Iceland	-	x	-	-	-	-	x	x	-	-	-
Ireland	-	x	-	-	-	x	-	-	-	x	-
Norway	-	x	-	-	-	x	-	x	-	-	-
Sweden	x	-	-	-	-	x	-	-	-	x	-
United Kingdom	-	x	-	-	-	-	x	-	-	x	-
										x	-
Southern Europe											
Albania	-	x	-	-	-	x	-	-	-	-	x
Greece	-	x	-	-	-	x	-	-	-	x	-
Holy See	x	-	-	-	x	-	-	x	-	-	-
Italy	-	x	-	-	-	x	-	x	-	-	-
Malta	x	-	-	-	x	-	-	x	-	-	-
Portugal	-	x	-	-	-	x	-	-	-	x	-
San Marino	x	-	-	-	x	-	-	x	-	-	-
Spain	-	x	-	-	-	x	-	-	-	x	-
Yugoslavia	-	x	-	-	-	x	-	-	-	x	-
										x	-
Western Europe											
Austria	-	x	-	-	-	x	-	x	-	-	-
Belgium	x	-	-	-	x	-	-	x	-	-	-

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No Modification	Rural configuration	Urban configuration	Rural and urban configuration
Western Europe (cont'd..)											
France	-	-	x	-	-	-	x	-	-	x	-
Germany Federal Rep. of	-	x	-	-	-	x	-	x	-	-	-
Liechtenstein	x	-	-	-	x	-	-	x	-	-	-
Luxembourg	x	-	-	-	x	-	-	x	-	-	-
Monaco	x	-	-	-	x	-	-	x	-	-	-
Netherlands	-	-	x	-	-	-	x	x	-	-	-
Zwitzerland	-	x	-	-	-	-	x	x	-	-	-
Western South Asia (part)											
Cyprus	-	x	-	x	-	-	-	-	-	-	x
Israel	-	x	-	-	-	x	-	-	-	-	x
Turkey	-	-	x	-	-	x	-	-	-	x	-
Northern America											
Canada	-	x	-	-	x	-	-	x	-	-	-
United States of America	x	-	-	-	x	-	-	x	-	-	-
Union of Soviet Socialist Republics											
Byelorussian SSR	-	x	-	-	-	x	-	-	-	-	x
Ukrainian SSR	-	x	-	-	-	x	-	-	-	-	x
USSR	-	x	-	-	-	x	-	-	-	-	x
Total	13	23	3	1	10	23	5	17	0	16	6
		39				39				39	

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
	Area of responsibility of the Economic Commission for Latin America										
Caribbean											
Bahamas	-	x	-	-	-	x	-	-	-	x	-
Barbados	x	-	-	-	x	-	-	x	-	-	-
Cuba	-	x	-	-	-	x	-	-	-	-	x
Dominica	-	x	-	-	x	-	-	x	-	-	-
Dominican Republic	-	-	x	-	x	-	-	x	-	-	-
Grenada	-	-	x	-	-	x	-	x	-	-	-
Haiti	-	-	x	-	-	x	-	-	x	-	-
Jamaica	-	-	x	-	-	x	-	-	x	-	-
Saint Lucia	-	x	-	-	x	-	-	x	-	-	-
Saint Vincent and the Grenadines	-	x	-	-	x	-	-	x	-	-	-
Trinidad and Tobago	-	-	x	-	-	x	-	-	-	-	x
Middle America											
Costa Rica	-	-	x	-	-	x	-	-	-	-	x
El Salvador	-	-	x	-	-	x	-	x	-	-	-
Guatemala	-	-	x	-	-	x	-	-	x	-	-
Honduras	-	-	x	-	x	-	-	x	-	-	-
Mexico	-	-	x	-	-	x	-	-	x	-	-
Nicaragua	-	x	-	-	-	x	-	x	-	-	x
Panama	-	-	x	-	-	x	-	-	-	-	x
Temperate South America											
Argentina	-	-	x	-	-	x	-	-	-	x	-
Chile	-	-	x	-	-	x	-	-	-	-	x
Uruguay	-	-	x	-	-	x	-	-	-	x	-
Tropical South America											
Bolivia	-	-	x	-	-	x	-	-	-	-	x
Brazil	-	x	-	x	-	-	-	-	-	-	x
Colombia	-	-	x	-	-	x	-	-	-	-	x

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No inter-vention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
Tropical South America (cont'd)											
Ecuador	-	-	x	-	-	x	-	-	x	-	-
Guyana	-	-	x	-	-	x	-	-	-	-	x
Paraguay	-	-	x	-	-	x	-	-	x	-	-
Peru	-	-	x	-	-	x	-	-	-	-	x
Suriname	-	-	x	-	-	x	-	-	-	-	x
Venezuela	-	-	x	-	-	x	-	-	-	-	x
Total	1	7	22	1	6	23	0	9	5	3	13
	30			30				30			

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
Area of responsibility of the Economic Commission for Western Asia											
Western South Asia											
Bahrain	x	-	-	-	x	-	-	x	-	-	-
Democratic Yemen	-	x	-	-	-	x	-	-	-	-	x
Iraq	-	x	-	-	-	x	-	-	-	-	x
Jordan	-	-	x	-	-	-	x	-	-	-	x
Kuwait	x	-	-	-	x	-	-	x	-	-	-
Lebaon	-	x	-	-	-	x	-	x	-	-	-
Oman	-	x	-	-	-	x	-	x	-	-	-
Qatar	x	-	-	-	x	-	-	-	x	-	-
Saudi Arabia	-	x	-	x	-	-	-	x	-	-	-
Syrian Arab Republic	-	x	-	-	-	x	-	-	-	-	x
United Arab Emirates	-	x	-	-	-	x	-	-	x	-	-
Yemen	-	x	-	-	x	-	-	x	-	-	x
Total	3	8	1	1	4	6	1	5	2	0	5
	12			12				12			

	acceptability of spatial distribution			Policies regarding basic trends in internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
Area of responsibility of the Economic and Social Commission for Asia and the Pacific											
China	-	x	-	-	-	-	x	-	-	-	x
Japan	-	-	x	-	-	x	-	-	-	-	x
Other East Asia											
Democratic People's Republic of Korea	-	x	-	-	-	x	-	-	-	-	x
Mongolia	-	x	-	-	-	x	-	-	-	x	-
Republic of Korea	-	x	-	-	-	x	-	-	-	-	x
Eastern South Asia											
Burma	-	x	-	-	-	x	-	-	x	-	-
Democratic Kampuchea	-	-	x	-	-	-	x	-	-	-	-
Indonesia	-	-	x	-	-	x	-	-	x	-	-
Lao People's Democratic Republic	-	-	x	-	-	x	-	-	-	-	x
Malaysia	-	x	-	-	x	-	-	-	-	-	x
Philippines	-	-	x	-	-	-	x	-	-	-	x
Singapore	x	-	-	-	x	-	-	x	-	-	-
Thailand	-	-	x	-	-	x	-	-	-	-	-
Viet Nam	-	-	x	-	-	-	x	-	-	-	x
Middle South Asia											
Afghanistan	-	x	-	-	x	-	-	-	-	-	x
Bangladesh	-	x	-	x	-	-	-	-	x	-	-
Bhutan	-	x	-	-	-	-	x	-	-	-	x
India	-	-	x	-	-	x	-	-	-	-	x
Iran	-	-	x	-	-	x	-	-	-	-	x
Maldives	-	x	-	-	-	x	-	-	-	-	x
Pakistan	-	-	x	-	-	x	-	x	-	-	-
Nepal	-	-	x	-	-	x	-	-	-	-	x
Sri Lanka	-	-	x	-	-	x	-	-	x	-	-
									x	-	-

	Perception of over-all acceptability of spatial distribution			Policies regarding basic trends internal migration				Policies regarding modification of rural and urban configuration of settlement			
	Appropriate	Partly appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration
Australia and New Zealand											
Australia	-	-	x	-	-	-	x	-	-	x	-
New Zealand	-	x	-	-	x	-	-	x	-	-	-
Melanesia											
Papua New Guinea	-	-	x	-	x	-	-	x	-	-	-
Solomon Islands	-	x	-	-	x	-	-	x	-	-	-
Micronesia-Polynesia											
Fiji	-	-	x	-	-	x	-	-	-	-	x
Kiribati	-	x	-	-	-	-	x	-	-	-	x
Nauru	x	-	-	-	x	-	-	x	-	-	-
Samoa	-	-	x	-	x	-	-	x	-	-	-
Tonga	-	x	-	-	-	x	-	x	-	-	-
Tuvalu	-	x	-	-	-	x	-	x	-	-	-
Total	2	15	16	1	8	16	8	9	7	2	15
	33			33				33			

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XXI.2. Governments' perceptions of the acceptability of spatial distribution of population, by areas of responsibility of regional commissions, geographical regions and level of development; statistical information, July 1980

	Perception of overall acceptability of spatial distribution			
	Appropriate	Partly appropriate	Inappropriate	Total
ECA Area:				
Eastern Africa	-	6	10	16
Middle Africa	-	1	8	9
Northern Africa	-	2	4	6
Southern Africa	-	2	2	4
Western Africa	-	3	13	16
Total	-	14	37	51
ECE Area:				
Eastern Europe	3	3	-	6
Northern Europe	2	5	-	7
Southern Europe	3	6	-	9
Western Europe	4	3	2	9
Cyprus, Israel, Turkey	-	2	1	3
Northern America	1	1	-	2
USSR	-	3	-	3
Total	13	23	3	39
ECLA Area:				
Caribbean	1	5	5	11
Middle America	-	1	6	7
Temperate South America	-	-	3	3
Tropical South America	-	1	8	9
Total	1	7	22	30

Table A.XXI.2 (Continued)

	Perception of overall acceptability of spatial distribution			
	Appropriate	Partly appropriate	Inappropriate	Total
ECWA Area:				
Western South Asia (part)	3	8	1	12
ESCAP Area:				
China	-	1	-	1
Japan	-	-	1	1
Other East Asia	-	3	-	3
Eastern South Asia	1	2	6	9
Middle South Asia	-	4	5	9
Australia and New Zealand	-	1	1	2
Melanesia	-	1	1	2
Micronesia-Polynesia	1	3	2	6
Total	2	15	16	33
Developed countries	13	22	4	39
Developing countries	6	45	75	126
Total	19	67	79	165

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XXI.3. Governments' policies with respect to basic trends in internal migration, by areas of responsibility of regional commissions, geographical regions and level of development; statistical information, July 1980

	Policies regarding basic trends in internal migration				
	Accelerate	No intervention	Decelerate	Reverse	Total
ECA Area:					
Eastern Africa	-	3	11	2	16
Middle Africa	-	1	5	3	9
Northern Africa	-	-	6	-	6
Southern Africa	-	1	2	1	4
Western Africa	-	6	9	1	16
Total	-	11	33	7	51
ECE Area:					
Eastern Europe	-	-	6	-	6
Northern Europe	-	1	4	2	7
Southern Europe	-	3	6	-	9
Western Europe	-	4	2	3	9
Cyprus, Israel, Turkey	1	-	2	-	3
Northern America	-	2	-	-	2
USSR	-	-	3	-	3
Total	1	10	23	5	39
ECLA Area:					
Caribbean	-	5	6	-	11
Middle America	-	1	6	-	7
Temperate South America	-	-	3	-	3
Tropical South America	1	-	8	-	9
Total	1	6	23	-	30

Table A.XXI.3. (Continued)

	Policies regarding basic trends in internal migration				
	Accelerate	No intervention	Decelerate	Reverse	Total
ECWA Area:					
Western South Asia (part)	1	4	6	1	12
Total	1	4	6	1	12
ESCAP Area:					
China	-	-	-	1	1
Japan	-	-	1	-	1
Other East Asia	-	-	3	-	3
Eastern South Asia	-	2	3	4	9
Middle South Asia	1	1	6	1	9
Australia and New Zealand	-	1	-	1	2
Melanesia	-	2	-	-	2
Micronesia-Polynesia	-	2	3	1	6
Total	1	8	16	8	33
Developed countries	-	11	22	6	39
Developing countries	4	28	79	15	126
Total	4	39	101	21	165

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.

Table A.XXI.4. Governments' policies with respect to configuration of settlement, by areas of responsibility of regional commissions, geographical regions and level of development; statistical information, July 1980

	Policies regarding modification of rural and urban configuration of settlement				
	No modification	Rural configuration	Urban configuration	Rural and urban configuration	Total
ECA Area:					
Eastern Africa	3	8	0	5	16
Middle Africa	1	4	0	4	9
Northern Africa	1	1	0	4	6
Southern Africa	2	0	0	2	4
Western Africa	7	3	0	6	16
Total	14	16	0	21	51
ECE Area:					
Eastern Europe	0	0	6	0	6
Northern Europe	3	0	4	0	7
Southern Europe	4	0	4	1	9
Western Europe	8	0	1	0	9
Cyprus, Israel, Turkey	0	0	1	2	3
Northern America	2	0	0	0	2
USSR	0	0	0	3	3
Total	17	0	16	6	39
ECLA Area:					
Caribbean	6	2	1	2	11
Middle America	3	1	0	3	7
Temperate South America	0	0	2	1	3
Tropical South America	0	2	0	7	9
Total	9	5	3	13	30

Table A.XXI.4. (Continued)

	Policies regarding modification of rural and urban configuration of settlement				
	No modification	Rural configuration	Urban configuration	Rural and urban configuration	Total
ECWA Area:					
Western South Asia (part)	5	2	0	5	12
Total	5	2	0	5	12
ESCAP Area:					
China	0	0	0	1	1
Japan	0	0	0	1	1
Other East Asia	0	0	1	2	3
Eastern South Asia	1	4	0	4	9
Middle South Asia	1	3	0	5	9
Australia and New Zealand	1	0	1	0	2
Melanesia	2	0	0	0	2
Micronesia-Polynesia	4	0	0	2	6
Total	9	7	2	15	33
Developed countries	18	0	16	5	39
Developing countries	36	30	5	55	126
Total	54	30	21	60	165

Sources: Compiled from United Nations Fourth Population Inquiry Among Governments in 1978 and Population Division, Population Policy Data Bank.